Mental Health Center of Denver

AUTHORIZATION TO RELEASE CONFIDENTIAL AND PROTECTED HEALTH INFORMATION

Name (please print) _____ DOB _____ MHCD ID # _____

In accordance with federal rules, 42 CFR part 2 (Confidentiality of Substance Use Disorder Patient Records) and 45 CFR part 164 (Health Insurance Portability and Accountability Act of 1996), **I authorize the release of information about me as indicated below.** I understand information about any of the following may be included in the release: behavioral health, sexuality and reproductive health, HIV/AIDS, sickle cell anemia, communicable diseases, drug and alcohol use, and treatment for a substance use disorder.

MHCD
Mental Health Center of Denver (MHCD)
4141 E. Dickenson Place
Denver, Colorado 80222
Phone _____ Fax _____

Third-party
Name _____
Address _____
City/State/Zip _____
Phone _____ Fax _____

Verbal (Oral) Communication: Do you authorize two-way verbal (oral) communication between MHCD and Third-party? ☐ Yes ☐ No

Written or Electronic Records: Do you authorize the release of records? ☐ Yes ☐ No
MHCD is authorized to release records? ☐ Yes ☐ No Third-party is authorized to release records? ☐ Yes ☐ No

Type of Records Authorized to Be Released

☐ All information maintained in my record ☐ Only the types of information/records checked below (check all that apply)

☐ Billing records	☐ Diagnosis list	☐ Employment info	☐ Physician summaries
☐ Clinical assessment(s)	☐ Discharge summary	☐ Laboratory results	☐ Progress summaries
☐ Continuity of care (CCD)	☐ Education plan (IEP)	☐ Medication history/orders	☐ Psychological testing
☐ Demographics	☐ Education records	☐ Parole/Probation info	☐ Psychiatric evaluations
☐ Other (must specify) _____			☐ Service/Treatment plans

Time Period (check only one)
☐ All admissions ☐ Most recent admission ☐ Dates _____ to _____

Purpose
☐ Continuity of care ☐ Coordination of services ☐ Treatment ☐ At the request of the individual
☐ Other (must specify) _____

Re-disclosure
I understand that information disclosed based on this Authorization, except for information about a substance use disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

Prohibition on Conditioning of Authorizations
I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. Mental Health Center of Denver may not refuse to treat me if I refuse to sign this Authorization, unless this Authorization is necessary for my participation in a research study or the purpose of the treatment is to provide information to the individual/entity identified in this Authorization.

Expiration and Right to Revoke (Cancel)
I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire two (2) years from the date I sign it unless an earlier date is specified here: _____.

Authorization
My signature below means I understand and accept the terms of this Authorization. A copy of this Authorization (including a fax) is as valid as the original. I have a right to receive a copy of the signed Authorization.

Signature of individual or authorized representative _____ Date _____

Name of authorized representative (please print) _____ Relationship _____
(Legal documentation of the representative's authority may be required.)

NOTICE TO RECIPIENTS
This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.