_____

Client ID#

RELEASE OF INFORMATION OR AUTHORIZATION

Medical Records Dept. - 116 Inverness Drive East Englewood CO 80112
P: 303-723-4270 / F: 303-996-1047 / E: records@allhealthnetwork.org

I, _____ _____/_____/_____
Consumer's First Name *Middle Initial* *Last Name* *Consumer's Date of Birth*

authorize the AllHealth Network to obtain information from, and share information with:

_____
Name of Doctor/Hospital/Person/Agency *Address, fax or email (you assume the risk if you provide an email)*

Please select one of the options below:

☐ **This is a request to have a copy of my records sent to the above listed doctor/hospital/person/agency**
To protect your privacy, if the recipient information is not clear no records will be released.

☐ **This is an authorization only. My records can be sent to the above listed doctor/hospital/person/agency if they request my information at a later date.**

Unless lined-through, information may include:

- Assessment/Diagnosis/Family History
- Treatment Summary and Recommendations
- Psychological Testing/Consultation
- Other _____
- Medical Information/Medications Prescribed
- Drug/Alcohol History and Treatment
- Service Plans

Purpose: At least one purpose below must be checked, otherwise this authorization is invalid.

☐ **Legal** ☐ **Coordination of care** ☐ **Other: _____**
☐ **Benefits determination** ☐ **Personal**

I understand that, unless lined-through, information to be released/authorized may include information regarding the following condition(s):

- Drug Abuse
- Alcoholism or Alcohol Abuse
- Psychiatric Conditions/Treatment
- HIV / Auto Immune Deficiency Syndrome (AIDS)

- **I understand that if this is a Release for "Treatment, Operations and Payment" purposes, AHN may withhold treatment, payment, enrollment or eligibility for benefits if I refuse to sign.**
- **I understand that if this is an Authorization for "Other" purposes, AHN may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not.**
- **If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42.C.F.R. Part 2.**
- **I understand that there is potential for information disclosed, as a result of this release/authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.**
- **I understand that I may revoke this release/authorization at any time by giving written notice to AHN, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on _____/____/_____, or if left blank, one year from the date of my signature, or as of the action or event of _____.**
- **I understand that I have a right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.**

_____ _____
Signature of Client/Parent/Legal Representative *Relationship to Client*

_____/_____/_____ _____
Date *Witness*

_____

Client ID#

NOTICE TO WHOM THIS INFORMATION IS GIVEN:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law.
Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

**If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/authorization.

I hereby revoke this Consent to Release / Authorization for Information.

_____	_____ /_____ /_____	_____	_____ /_____ /_____
Consumer's Signature	*Date*	*Witness*	*Date*