
 Client ID#

RELEASE OF INFORMATION OR AUTHORIZATION

Medical Records Dept. - 155 Inverness Drive West Englewood CO 80112 P:303-723-4270 / F: 303-996-1047

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 City, State, Zip

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

Check only one box to indicate the purpose for which information is to be authorized/released:

- Treatment, Operations or Payment (If checked, this form becomes a **Release** and services can be refused if you refuse to sign)
 Specify: _____
- Other [e.g., Law (attorneys, probation), Education (schools) or Social Services] (If checked, this form becomes an **Authorization** and under HIPAA rules, services may not be conditioned or refused if you refuse to sign.)
 Specify: _____

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