MRN: _____ revised 12/1/17
Provider: _____

Authorization to Request / Release Information

Client Name: _____ Client Date of Birth: _____ Last 4 of SSN: _____

I authorize that information may be exchanged between the following:

Colorado Coalition for the Homeless
Attn Program: _____
Address: _____
City, State Zip: _____
Phone Number: _____
Fax Number: _____

Name or Organization Name: _____
Relationship to Client: _____
Address: _____
City, State Zip: _____
Phone Number: _____
Fax Number: _____

Information to be released (please mark items below to be released): Information from Medical Programs:

___ Medical Provider Notes ___ Imaging/X-rays ____Consultant Reports ____Operative Reports
____Lab Results ____ Immunizations ____Medication List ____ ER Reports
____ Hospital Admit/Discharge Summaries ____ AIDS/HIV Information ____Dental Records
____ Billing Records ___ Demographic/Face Sheet ____ Other: _____

Information from Mental Health Programs:

____ Lab Results ____ Progress Notes ___ Medication History ___Treatment Plan ___Diagnoses
____ Psychiatric Visit Notes ____ Discharge Summary ___ Treatment Status ___ Intake & Assessment

Information from Substance Treatment Programs:

____ Substance Use Diagnosis ____ Substance Use Progress Notes ____ Substance Use Lab Results
____ Substance Use Discharge Summary ____ Substance Use Clinical Assessments
____ Substance Use Treatment Status ____ Substance Use Treatment Plan

Information from Housing/Case Management Programs:

____ Family/Social Composition ___ Voucher/Lease Information ____Program Status ___Benefit Information
____ Case Notes/Case Management Notes ____ Other: _____

____ All My Records _____ Specific Dates of Service: _____ Electronic Copy

Please indicate the purpose of this release (check all that apply)

____ Continuity of Care ___Insurance ____ Obtain Benefits
____ Legal ___Worker's Compensation ____ Referral
___ Obtain/ Maintain Housing ___ Personal/Other_____

Authorization

I understand that:

- Due to the integrated care provided by the Colorado Coalition for the Homeless information released may include a diagnosis or reference to the following condition(s): behavioral health /psychiatric care; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or substance use disorders.
- I understand that treatment and payment may not be conditioned on signature of this form.
- Individuals enrolled in our licensed Substance Treatment teams have their substance-specific records protected by 42CFR Part 2. Further disclosure of this information are prohibited unless further disclosure is expressly permitted by the written consent of whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
- I understand that I may revoke this authorization at any time (except to the extent that the action has been taken to comply with it).
- If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected by the HIPAA Privacy Rule.

Expiration

I understand that this release expires on: _____ (not to exceed two years from today's date)

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Personal Representative Printed Name Relationship to Patient

_____ _____
Witness Date