COLORADO COALITION FOR THE Homeless Creating Lasting Solutions

MRN:_____ DOB: _____

CATEGORY: ROI

Authorization to Request / Release Health Information

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

I authorize that information may be exchanged between the following:

◯ From ◉ To **(please select)**

Name: _____
Attn: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____
Email: _____

◯ From ◉ To **(please select)**

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

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

☐ Continuity of Care
☐ Legal
☐ Obtain/Maintain Housing
☐ Insurance
☐ Worker's Compensation
☐ Personal/Other _____
☐ Obtain Benefits
☐ Referral

Information to be released (please check all that apply):

☐ Paper Copy ☐ Verbal Exchange ☐ Electronic Copy
☐ Specific Dates of Service: _____

Medical Information:

☐ Progress Notes
☐ Lab Results
☐ AIDS/HIV Information
☐ Demographic/Face Sheet
☐ Imaging Reports
☐ Immunizations
☐ Dental Records
☐ Diagnoses
☐ Consultant Reports
☐ Medication List/History
☐ Billing Records
☐ Hospital Admit/Discharge Summaries
☐ Operative Reports
☐ ER Reports
☐ Eye Care Records

Mental Health Information:

☐ Progress Notes
☐ Lab Results
☐ Discharge Summaries
☐ Demographic/Face Sheet
☐ Psychiatric Notes
☐ Treatment Plan
☐ Treatment Status
☐ Diagnoses
☐ Intake/Assessment
☐ Medication List/History
☐ Billing Records
☐ Hospital Admit/Discharge Summaries

Housing Information:

☐ Program Status
☐ Family/Social Composition
☐ Notices/Eviction Information
☐ Case Notes or Housing Advocate Notes
☐ Voucher/Lease Information
☐ Demographic/Face Sheet

Case Management Information:

☐ Program Status
☐ Family/Social Composition
☐ Intake/Assessment
☐ Benefit Information
☐ Case Notes/Case Management Notes
☐ Treatment/Care Plan
☐ Demographic/Face Sheet

Substance Treatment Information:

☐ Progress Notes
☐ Lab Results
☐ Discharge Summaries
☐ Assessments
☐ Treatment Plan
☐ Treatment Status
☐ Medication List/History
☐ Billing Records
☐ Diagnoses

Authorization
I understand that:

- Due to the integrated care provided by CCH, 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.
- Individuals enrolled in CCH licensed substance treatment (Part 2) programs have their substance-specific records protected by 42 CFR Part 2
- I understand that treatment and payment may not be conditioned on signature of this form.
- I understand that authorizing the disclosure of this information is voluntary.
- I understand that I may revoke this authorization at any time by giving written notice to the Colorado Coalition for the Homeless, except to the extent that CCH has already acted on this request.
- I understand that when information is released, it carries with it the potential for unauthorized redisclosure and it may no longer be protected by federal confidentiality rules such as HIPAA.
- I understand that I may make a written request for a list of the entities to which my information has been disclosed over a specified period, not to exceed six years preceding the date of my request.
- I understand that if I request to receive records via unsecured email, unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone.

Expiration
I understand that this release expires on: _____ (not to exceed two years from the date of my signature)

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Client or Personal Representative Printed Name Relationship to Client

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (HIPAA and 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.

Revocation of Authorization to Release Protected Health Information

I hereby revoke the authorization to release information that I provided to Colorado Coalition for the Homeless allowing CCH to use and disclose my Protected Health Information as outlined on the authorization form, which I signed on _____. I understand that this revocation does not apply to any action Colorado Coalition for the Homeless has taken in reliance on any authorization I signed earlier.

This revocation does not revoke any and all previous authorizations to release information that I have provided to Colorado Coalition for the Homeless.

Client's signature: _____ Date: _____