MRN:_____ DOB: _____

CATEGORY: ROI

Authorization to Request / Release Health Information

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

Dates Of Service To Disclose: __ Specific (from ____/____/_____ to ____/____/_____) *OR* ___All

I authorize that information may be exchanged between the following:

___ From ___ To **(please select)**	___ From ___ To **(please select)**
Colorado Coalition for the Homeless	Name or Organization Name: _____
Attn: **Health Information Management**	Relationship to Client: _____
Address: **2130 Stout Street**	Address: _____
City, State, Zip: **Denver, CO 80205**	City, State Zip: _____
Phone Number: **(303) 293-2220**	Phone Number: _____
Fax Number: **(303) 296-8826**	Fax Number: _____
Email: **records@coloradocoalition.org**	Email: _____

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 _____

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

___ Paper Copy ___ Verbal Exchange ___ Electronic Copy

Medical Information:

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

Mental Health Information:

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

Housing Information:

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

Case Management Information:

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

Substance Treatment Information:

___ Progress Notes ___ Assessments ___ Medication List/History
___ Lab Results ___ Treatment Plan ___ Billing Records
___ Discharge Summaries ___ Treatment Status ___ 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: _____