Release of Information

Patient Information

Instructions: Fill in the appropriate information in each applicable section. Sign and date the form. A separate authorization must be completed for each request.

Patient Full Name: ____ **Date of Birth:** _______________________
Age:__________________

Phone Number: _____________________________

Patient Address: _____________________________________ **City:**_____________________________
State:_________ **Zip:**____________

Authorization of Release/Exchange of Information
I hearby authorize:
West Pines Behavioral Hospital
11455 Huron Street
Westminster, CO 80234
Phone: 303-285-5401

☐ Release information to ☐ Exchange information with

Name: _______________________________________
Address:____

Phone: _______________________________________ Fax:____

By signing below, I hereby authorize West Pines Behavioral Health or agent, to disclose information contained in the medical and financial record of the patient identified, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable disease or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities. Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

The following information is requested: (patient or legal guardian check items to be released):

☐ Psychiatric Evaluation	☐ Laboratory Results	☐ Financial Account Information
☐ History & Physical	☐ Immunization Records	☐ Practitioner Orders
☐ Medication Records	☐ Practitioner Progress Notes	☐ Treatment/Individualized Service Plan
☐ Discharge Summary	☐ Discharge Summary	☐ Complete Medical Record

Date(s) of Service: ____

Other(specify):

____

____

____

The Purpose or Need for Disclosure is:

- ☐ To Transfer Client Care
- ☐ To Aid in Treatment
- ☐ Application for Provider Coverage
- ☐ For Follow Up Care
- ☐ For Discharge Planning
- ☐ Psychological Report
- ☐ To Inform Family
- ☐ To Update Medical Records
- ☐ To Aid in Financial Account Activity
- ☐ Referral Source
- ☐ Employer
- ☐ Legal/Court System

Other(specify):

____

____

____

Substance Abuse, Mental Health and HIV Records

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
State and federal law protect the following information. If this information applies to you, please indicate if you would like this information release/obtained (include dates of records where appropriate):

Alcohol, Drug or Substance Abuse Records

☐ Yes ☐ No

Alcohol, Drug or Substance Abuse Records: Date of records

Starting Date: ____________________ to: Ending Date: ________________________

HIV Testing and Results

☐ Yes ☐ No

Mental Health Records

☐ Yes ☐ No

Mental Health Records: Date of records

Starting Date: ____________________ to: Ending Date: ________________________

Disclosure Format

☐ Paper ☐ US Mail ☐ Fax ☐ Other

Authorization

The authorization will expire on the date you select below. The expiration date chosen must be no more than 180 days from the date signed below (today's date).

--I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
--I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.
--I Understand that the facility listed below will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this information.

West Pines Behavioral Hospital
11455 Huron Street

Westminster, CO 80234
Phone: 303-285-5401

Authorization expires on: ____________________

Patient or Authorized Representative Signature

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

Patient or Authorized Representative Signature: ________________________________ Date: __________________ Time: ______________

Print Name, Relationship to Patient (if applicable): ____

☐ Unable to Sign ☐ Refused to sign

Revocation of ROI

☐ Revocation of ROI

Notice to Recipient

--This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws.

--No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.