RELEASE OF INFORMATION OR AUTHORIZATION **FORM #**
HIPAA 0501-03

I authorize the Weld County Department of Social Services to ☐ **release or** ☐ **receive** the information indicated to/from the agency or persons listed below for purposes of service coordination, continuity of care and case management.

The authorization pertains to:
(Please print) ____
Client Name Date of Birth

Information to be released or requested: (Check every box applicable.)

☐ **All medical and mental health treatment records which includes mental health condition and treatment, for all dates of treatment:** Including, but not limited to ☐ clinical charts, ☐ office notes, ☐ test reports, ☐ test data, ☐ physician notes, ☐ notes of Progress-to-Date, ☐ consultation reports and notes, ☐ outpatient records, and ☐ correspondence related to clinical matters.

☐ **Verbal Communications:** Including communication either verbally or in writing with the person(s) or entity(ies) listed below, regarding all the released information available, including information contained in treatment records as described above, and is authorized to give opinions and answer questions.

☐ **Drug abuse or alcohol abuse, which includes, if any, alcohol and substance abuse condition and treatment information.** Includes all information regarding any assessment, diagnosis, referral, history, or discussion of drug abuse or alcohol abuse.

☐ **Other:** Department of Social Services records, including information regarding the pending dependency and neglect action and treatment plan compliance.

☐ **Other:** Urinalysis or other drug test results

☐ **Other:** Attendance, progress, participation, and recommendations ______________________.

☐ **Other:** ____.

Information to be ☐ released to or ☐ received from:

Name of agency or person Address/Telephone

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- I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of drug abuse and/or alcohol abuse information that the confidentiality of this information is protected by Federal Law [42 CFR, Part 2]. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time. Copies of this form may be used in lieu of the original. I understand and agree that this release form may be sent to the agencies and persons identified above.
- This disclosure is at the request of the individual or legal authority or _____n/a_____. This disclosure is for the purpose of ☐ **Treatment**, ☐ **Payment**, ☐ **Operations**, or ☐ **Other**. If "Other" is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, the Center may not condition treatment, payment, enrollment, or eligibility for benefits on your signing this Authorization. Also, if this is an Authorization, the Center must provide you with a copy.
- I understand that there is a 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 regulations.
- This consent expires and cannot be used past the following date (Not to exceed one (1) year): ____________________

____
Signature Date

____
If not the client, please print and state your legal authority to sign for client Date

____
Witness Signature Date

I hereby revoke this consent to Release/Authorization for Information.

____
Client and Signature **Date** **Witness Signature** **Date**