AURORA MENTAL HEALTH CENTER

11059 East Bethany Drive Suite 200 • Aurora, CO 80014 • Ph 303.617.2300
AuMHC Contact Person: Fx 303.617._____ Ph 303.617._____

AUTHORIZATION TO RELEASE INFORMATION

_____ _____ _____ _____
Client Name (please print) Social Security Number Date of Birth CID

I authorize Aurora Mental Health Center to <u>exchange</u> information with:

_____ _____
Name of Person or Organization Phone

_____ _____
Street Address Fax

_____
City / State / Zip Code

The information to be disclosed includes the following <u>checked</u> documentation:

___ Medication History ___ Psychiatric / Psychological Evaluations ___ Progress Notes
___ Service Plans ___ Lab Studies ___ Discharge Summaries

Dates include: ___ Last 4 weeks ___ Last 6 months ___ Last year ___ Other: From_____To_____

The purpose for the release is: **___** Continuity of care _____ Other _____

I UNDERSTAND that the information to be released may include information related to drug abuse and alcoholism or alcohol abuse; and that this information is protected by federal law [42 CFR Part 2]. The released information may also include psychiatric and HIV / AIDS conditions.

I UNDERSTAND that the information disclosed pursuant to this Authorization might be re-disclosed by the recipient and might be no longer protected by the Federal Privacy Regulation [45 CFR Part 164].

UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This Authorization will expire on _____ (date), or, if left blank, one year from the date of my signature. I release the Center from all liability for disclosing the requested information.

I UNDERSTAND that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules [42 CFR Part 2 and 45 CFR Part164]. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Please print name of Legal Representative. Phone

If you are a Legal Representative, please circle one: Parent of minor / Guardian / Custodian / GAL
MDPOA / Personal Representative (Executor of Estate)

I hereby revoke this Authorization to Release Information.

_____ _____
Signature of Client or Legal Representative Date

A copy or facsimile of this Authorization is as valid as the original.