

**BOULDER COUNTY PUBLIC HEALTH
SUBSTANCE ABUSE PROGRAMS
3450 Broadway • 441-1275
Boulder, CO 80304**

AUTHORIZATION FOR RELEASE OF INFORMATION

All blanks must be completed or marked N/A (not applicable)

I _____ hereby authorize
(Name of client) (Date of birth)

BOULDER COUNTY PUBLIC HEALTH (ARC) and
(Name of person/program/agency releasing/receiving information)

_____ to release and exchange
(Name of person/program/agency receiving/releasing information)

between them the information specified below, including protected health information.

This consent is valid for no longer than the period of time necessary to carry out the stated purpose of the request for information unless otherwise noted below.* The consent may be revoked at any time by myself unless I am participating in the program as a formal condition of probation, parole, or release of confinement in which case the consent cannot be revoked until there is a formal termination or revocation of release from confinement, probation or parole.

I specifically authorize the release of information regarding the following condition(s): *(Initial appropriate items)*

Drug abuse _____ Alcohol abuse _____ Psychological or psychiatric conditions _____ HIV/AIDS _____.

INFORMATION TO BE RELEASED AND/OR OBTAINED

PURPOSE OF RELEASE

() Yes () No Alcohol / Drug Recommendations

() Yes () No At the request of the patient

() Yes () No Diagnosis

() Yes () No Assessment

() Yes () No Discharge Summary

() Yes () No Continuity of Care

() Yes () No Complete medical record

() Yes () No Service Planning

() Yes () No Psychological/Psychiatric Testing/Evaluation

() Yes () No Compliance with court ordered treatment

() Yes () No Summary of Treatment/Recommendations

() Yes () No Other:

I understand that generally I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive treatment or payment or my eligibility for benefits, but that in certain limited circumstances I may be denied treatment if I do not sign this form. I may inspect/copy any information used/disclosed under this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

Date/Signature of Client

OR

Parent/Guardian of Minor Child

Witness

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). 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. A general authorization for release of information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.

*Revocation Date Signature of Client
expire:

Unless otherwise revoked, this Release of Information (ROI) will

- 30 days after discharge
- End of probation / parole
- Other _____