Consent for Use and/or Disclosure of Protected Health Information

1. **AUTHORIZATION**: I hereby authorize the use or disclosure of protected health information about me as described below. I understand that the information to be released and/or requested does not pertain to the exceptions to confidentiality as outlined in 42 CFR Federal confidentiality regulations

Client: ____
(Last Name) (First Name) (Middle Name) (Maiden Name)

Date of Birth: ____________________ Client ID #: ____________________

Address: ____

Authorize: [ ] High Country Behavioral Health Staff or [ ] Other____________________

To exchange information with: ____
(Specific description of person(s) and/or Organization)

2. INFORMATION TO BE USED OR DISCLOSED: (Place a check mark [_] next to the information to be used or disclosed, **then have client initial.**)

[ ] Diagnosis
[ ] Results of Psychiatric Testing
[ ] Treatment Planning Information
[ ] Number of un/kept appointments
[ ] Psychiatric Evaluation
[ ] Assessment Information
[ ] Reason for Termination
[ ] Recommendations
[ ] Medication(s)
[ ] Communicable Disease Information
[ ] Progress Notes
[ ] Other: ____________________

3. PURPOSE OR NEED FOR USE OR DISCLOSURE: (Place a check mark [_] next to the reason for use or disclosure, **then have client initial.**)

[ ] Collaboration with School
[ ] For client treatment
[ ] To comply with Court Order
[ ] Other: ____

4. [ ] This information may be shared by fax, e-mail, telephone or documents sent by mail.

5. This authorization will expire as noted below: (Place a check mark [_] next to the duration, **then have client initial.**)

[ ] At the end of 60 days
[ ] At termination of my treatment or at the end of 1 year, whichever is first
[ ] At the happening of the following event or date (less than 1 year from date signed):____________________

6. I understand that I may revoke this authorization by completing Part 9 below. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by High Country Behavioral Health in reliance on this authorization.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

8. I understand that my records are protected by federal and state laws and cannot be disclosed without my written permission, except as noted in High Country Behavioral Health's Notice of Privacy Practices. I UNDERSTAND THAT THIS RELEASE ALSO INCLUDES ANY REFERENCE TO DRUG AND OR ALCOHOL TREATMENT AS PROTECTED BY FEDERAL LAW.

______________________________ ______________________________
(Signature of Client or Representative) (Date of Signature) (Witness Signature) (Date of Signature)

______________________________ ______________________________
(Printed Name of Client or Representative) (Description of Representative's Authority to Act for Client, i.e. Relationship)

9. REVOCATION: I wish to revoke this authorization: ____________________ Date: __________
(Signature of Client or Representative)

Person witnessing revocation: ______________________________ Date: __________

NOTE: The receiving individual or organization understands that it IS NOT TO RE-RELEASE any of the confidential information received. Once the information is used and/or disclosed by HCBH, it is no longer protected by the federal privacy regulations and may be subject to re-disclosure by the recipient.