



Client ID# _____

RELEASE OF INFORMATION OR AUTHORIZATION

Medical Records Dept. - 6400 S Fiddlers Green Cir Ste 323 Greenwood Village, Co 80111

P: 999-999-9999

E: recovery.hub.team@gmail.com

I, _____ / _____ / _____
Consumer's First Name Middle Initial Last Name Consumer's Date of Birth

authorize the Recovery Hub to obtain information from, and share information with:

Name of Doctor/Hospital/Person/Agency

Address, fax or email (you assume the risk if you provide an email)

Please select one of the options below:

- ☐ This is a request to have a copy of my records sent to the above listed doctor/hospital/person/agency
To protect your privacy, if the recipient information is not clear no records will be released.
- ☐ This is an authorization only. My records can be sent to the above listed doctor/hospital/person/agency if they request my information at a later date.

Unless lined-through, information may include:

- Assessment/Diagnosis/Family History
- Treatment Summary and Recommendations
- Psychological Testing/Consultation
- Other _____
- Medical Information/Medications Prescribed
- Drug/Alcohol History and Treatment
- Service Plans

Purpose: At least one purpose below must be checked, otherwise this authorization is invalid.

- ☐ Legal ☐ Coordination of care ☐ Other: _____
☐ Benefits determination ☐ Personal

I understand that, unless lined-through, information to be released/authorized may include information regarding the following condition(s):

- Drug Abuse
- Alcoholism or Alcohol Abuse
- Psychiatric Conditions/Treatment
- HIV / Auto Immune Deficiency Syndrome (AIDS)

- I understand that if this is a Release for "Treatment, Operations and Payment" purposes, RH may withhold treatment, payment, enrollment or eligibility for benefits if I refuse to sign.
- I understand that if this is an Authorization for "Other" purposes, RH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not.
- If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42.C.F.R. Part 2.
- I understand that there is 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 Regulation.
- I understand that I may revoke this release/authorization at any time by giving written notice to RH, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on _____/_____/_____, or if left blank, one year from the date of my signature, or as of the action or event of _____.
- I understand that I have a right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

Signature of Client/Parent/Legal Representative

Relationship to Client

Date

Witness

Client ID# _____

NOTICE TO WHOM THIS INFORMATION IS GIVEN:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law.

Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

**If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/authorization.

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

Consumer's Signature

____/____/____
Date

Witness

____/____/____
Date