RMHS
Rocky Mountain Human Services

AUTHORIZATION TO RELEASE AND SHARE PROTECTED HEALTH INFORMATION (PHI)

I hereby consent to and authorize Rocky Mountain Human Services and its employees to obtain from and share individually identifiable protected health information with the providers or organizations listed below, for the purpose(s) as described below. I may also use this form to request a copy of my records for my personal use.

Client Name: _____

Date of Birth:_____ Last 4 Digits SSN: _____

I authorize the sharing of health information and records between Rocky Mountain Human Services and the person, entity or agency described below:

Person, Entity or Agency	Name(s)	Address/Phone
Physicians involved in my care:		
Providers involved in my care:		
Family Members/Legal Representatives:		
Hospitals/Facilities/Nursing Home agencies involved in my care:		
Home Health and/or Hospice agencies involved in my care:		
Other: (Specify)		

I also understand that my information may be released to agencies such as those listed below, that are involved with my care and treatment.

- Colorado Department of Human Services
- Single Entry Point (SEP) Agencies
- Community Center Boards (CCBs)
- Colorado Department of Health Care Policy and Financing (HCPF)
- Colorado Department of Local Affairs (DOLA)/Division of Housing (DOH)
- Colorado Department of Public Health and Environment (CDPHE)

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DESCRIPTION OF INFORMATION TO BE RELEASED: Check all that apply

	Indicate Specific Date or Date Range for Release	**DATES:**		**Indicate Specific Date or Date Range for Release**	**DATES:**
☐	Demographic Information		☐	Assessments/Evaluations	
☐	Service Plans//Treatment Plans/IEP's/IFSP's		☐	Applications/Eligibility Determinations	
☐	Health Information or medical records		☐	Other: (Specify)	

*** Excludes Psychotherapy Notes**

THE PURPOSE OF THIS DISCLOSURE IS: Check all that apply

☐	At Request of Client/Personal Use	☐	Transition of Care/Planning
☐	Case Management/Service Coordination/Care Coordination	☐	Eligibility Determination
☐	Other: (Specify)		

I understand that information disclosed by this authorization except for Alcohol and Drug Abuse information as defined in 42 CFR Part 2 may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a). I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that this authorization is voluntary.

I also understand that I may revoke this authorization at any time. I further understand that any release of information prior to the rescinded date is legal and binding. I also understand that I may decline to sign this authorization and that my services will not be affected if I do not sign, except that for purposes of determining eligibility for services, eligibility may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization and that I may see and copy the information described on this form if I ask for it. I understand that I may request a list of entities to which my information has been disclosed.

I understand that unless I specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, or for up to one year from date of signature. This authorization will expire on ____/____/____ (MM/DD/YY).

I understand and agree that my electronic signature on this authorization is valid and is the legal equivalent of my handwritten signature.

(Signature of Client/Guardian)		*(Date)*
(Printed Name)	*(Relationship to Client)*	
(Witness, If Required)		*(Date)*

A copy of this document will be valid as the original.