Antelope Recovery
1035 Pearl Street 313
Boulder, CO 80302-5130

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Client Name Date of Birth

Client Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form in accordance with the Colorado State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Federal Law 42 C.R.S. Part 2, I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-RELATED INFORMATION only if I specifically authorize release of such information to the person/agency indicated by checking the corresponding boxes in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release of disclosure of HIV-related information, I may contact the Colorado Civil Rights Division at 303-894-2997 or toll-free at 1-800-262-4845.
3. I have the right to revoke this authorization at any time by writing to the healthcare provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. The authorization will automatically expire after two years from the date of my signature.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

I authorize Antelope Recovery, 1035 Pearl Street 313, Boulder, CO 80302-5130

6. To:
   - ☐ Send
   - ☐ Receive
   - ☐ Verbally communicate

7. Name and address of the health provider or entity to release this information:

_____

8. Specific information to be released and/or discussed:
   - ☐ Entire Mental Health Treatment Record
   - ☐ Intake/diagnostic Evaluations

- ☐ Psychological testing
- ☐ Treatment/discharge summary
- ☐ Therapy Progress Notes
- ☐ Education Records
- ☐ Medical Records, including patient histories, medical history and physical exams, office notes (except psychotherapy notes), test results, referrals, consults, billing records, insurance records, and records provided by other health care providers
- ☐ Alcohol/Drug Treatment
- ☐ HIV-related Information

9. The above information will be used for the following purposes:
   - ☐ Treatment planning
   - ☐ Care coordination
   - ☐ Determining eligibility for benefits or programs
   - ☐ Other _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____

Signature of client or representative authorized by law Date