Please check one: Send Information Now_____ Request Information Now_____ File for Future/As Needed Use_____ One-time release only_____

LAS ANIMAS COUNTY DEPT. OF HUMAN SERVICES
MENTAL HEALTH SERVICES
219 S. Chestnut Street | Trinidad, CO 81082 Phone 719-846-2276 Fax 719-846-4269
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name:_____ Client's Date of Birth: _____
(Include client's AKA, maiden name, etc. of person receiving services at MHP)

I authorize that information may be exchanged between the following named individual or entity and Las Animas County Department of Human Services (LACDHS) Mental Health Services:

*Name: _____ Relationship to Client: _____
Address/e-mail: _____ Phone: _____
_____ FAX: _____

☐ *Check here if this is for your Primary Care Physician*
☐ *Check here if you want to authorize release of your substance use disorder treatment information to all your past, present and future treatment providers as a general designation authorization*

***If using this form to release your MENTAL HEALTH TREATMENT information to anyone who is NOT 1) providing treatment, or 2) paying for treatment you must indicate a specific individual (not an agency or entity) to receive that information by their first and last name.**

The purpose of the disclosure is: (It is required to check one of the purposes below or provide a specific purpose)

_____ Client requested letter _____ Coordination of care _____ Communicate about therapy results and/or attendance
_____ Obtain/maintain housing _____ Obtain/maintain benefits _____ Obtain/maintain employment/supported employment
Other (Please Specify): _____
_____
_____

Please check any items below to release the following information:

_____ **All my physical and mental health treatment records, Including HIV/AIDS (unless restricted below)
_____ **All my substance use disorder treatment (drug and alcohol) records (this can be restricted below)

_____ Diagnosis
_____ Medications
_____ Progress Notes
_____ Treatment Plan(s)
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Emergency Services Reports (§ 27-82 commitments)
_____ Psychiatric Progress Notes
_____ Employment
_____ Benefits
_____ **HIV/AIDS
_____ **Drug and Alcohol Evaluations
_____ Physical Examination
_____ Information provided by client to receive benefits
_____ Service Attendance Dates
_____ Lab Reports
_____ Patient Assistance Program (PAP) Information
_____ Intake/Admission Information
_____ Information needed to complete application for organization
_____ Discharge Summary
_____ Housing
_____ Education
_____ Other (Please Specify additional items to release) _____
_____

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse (*protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions, and any other information in your medical record **unless restricted as follows**: _____
_____

Once information is disclosed pursuant to this signed authorization, I understand that the general federal privacy law (45 C.F.R., Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to the LACDHS Privacy Officer or his/her designee. If not revoked earlier, this release/authorization will expire **two years** from the most recent date signed. I hereby release the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same effectiveness as an original. I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at LACDHS.

LACDHS does not recommend electronic format (such as e-mail, texting with clinical staff) as a means of communication with LACDHS employees. There is some risk that any protected health information that may be contained in such e-mail or text may be disclosed to, or intercepted by, unauthorized third parties. By signing this form, you are acknowledging that electronic media is not secure, and you are releasing LACDHS from any liability relating to unauthorized disclosure of PHI contained in electronic media correspondence. Charges for copies may apply.

(***Optional***) I restrict this release to the following dates of service: ___/___/_____ and ___/___/_____.

_____ _____
Signature of Client, Parent/Guardian (for client under 18 years of age), or Authorized Representative, including your authority to act for client

Date of Signature

_____ _____
Signature and Date to Extend Request

Signature and Date to Extend Request

_____ _____
Signature and Date to Extend Request

Signature and Date to Revoke Authorization

Rev. 04/2023