

# Highlands Behavioral Health System

## Authorization to Use or Disclose Protected Health Information

Patient Name _____	Date of Birth _____
Address (Street, City, State, Zip Code) _____	Phone _____

**Release To/From:**  To: \_\_\_\_\_  From: \_\_\_\_\_ Relation \_\_\_\_\_

Highlands Behavioral Health System  
 8565 South Poplar Way  
 Littleton, CO 80130

Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

<b>Treatment Dates</b> <input type="checkbox"/> All Admissions This Facility <input type="checkbox"/> This Admission Only <input type="checkbox"/> Treatment Dates from _____ to _____	<b>Purpose of Disclosure</b> <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Summary of Treatment & Progress <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> DC Planning <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Progress During Treatment <input type="checkbox"/> Facilitation of Treatment, Progress, & Support <input type="checkbox"/> Other _____
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**The following information is to be Disclosed**

<input type="checkbox"/> Verbal Exchange Only	<input type="checkbox"/> Release of the Entire Medical record for the treatment Dates Listed Above
<input type="checkbox"/> Notification of Admission	<input type="checkbox"/> Notification of Discharge
<input type="checkbox"/> Discharge Plan	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychosocial	<input type="checkbox"/> Comprehensive Assessment
<input type="checkbox"/> MARS	<input type="checkbox"/> Labs
<input type="checkbox"/> Medication Reconciliation	<input type="checkbox"/> Other _____
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Medical History & Physical
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Physician Progress Notes
<input type="checkbox"/> Radiology	<input type="checkbox"/> EKG

**Documents to be restricted from disclosure:** \_\_\_\_\_

**Redisclosure:** I understand that if the requestor or receiver is not a health care provider or health care plan the released information may no longer be protected by federal privacy regulations and may be redisclosed. However, the recipient may be prohibited from disclosing substance abuse information under the Substance Abuse Confidentiality Requirements.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to: HIM Manager Highlands Behavioral Health System 8565 S. Poplar Way, Littleton, CO 80130. If I revoke this Authorization, it will not have any affect on actions taken prior to receiving the revocation.

**Other Rights:** I understand that:

- My signature on this form is strictly voluntary & I may refuse to sign this Authorization
- My treatment, payment, enrollment or eligibility for health care benefits may not be conditioned on signing this Authorization except as follows: (a) the provision of research related treatment may be conditioned on obtaining an Authorization for the use and disclosure of protected health information for research that includes treatment; and (b) the provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a 3<sup>rd</sup> party may be conditioned on obtaining an Authorization for disclosure of protected health information to such 3<sup>rd</sup> party (e.g. employment drug testing). Otherwise, my refusal to sign this Authorization will have the following consequence: This information will not be disclosed.
- I understand that I may see & obtain a copy of the information described in this form, for a reasonable fee if I ask for it.

**Expiration:** Unless previously revoked, this Authorization expires in **sixty(60)** days from the date of signature.

**Other Conditions:** A copy or facsimile of this Authorization signed by me, may be used as if it were an original.

**ACKNOWLEDGEMENT:** I request & authorize the above-named organization or individual to release the information specified above to the organization or individual named on this request. **I ACKNOWLEDGE AND HEREBY CONSENT THAT THE RELEASED INFORMATION MAY CONTAIN INFORMATION REGARDING THE FOLLOWING CONDITIONS: SICKLE CELL ANEMIA, GENETIC TESTING, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), HUMAN INNUNODEFICIENCY VIRUS (HIV)INCLUDING TESTING OR RESULTS, DRUG ABUSE OR DEPENDENCY, ALCOHOL ABUSE OR DEPENDENCY, AND PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS** \_\_\_\_\_ (Initial)

**Signature:** My signature is required to validate this Authorization.

	Date		Date
	Date		Date/Time

This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. HBHS is not liable for such re-disclosures.

**Copy of ROI given:**  Yes  Pt Declined Date/Time: \_\_\_\_\_ / \_\_\_\_\_

Staff Initials:  
 Print HBHS Staff Name:  
 ROI (Rev. 07/21)  
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 Email: highlandsmr@uhsinc.com