DIVERSUS HEALTH
PO Box 15318, Colorado Springs, CO 80935
Phone number 719-314-4283 and fax number 719-314-4257
Email: MedicalRecords@DiversusHealth.org

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name:_____ Client ID: _____

DOB:_____ Effective:_____

I do hereby consent and authorize Diversus Health to:

☐ Get information from and/or
☐ Release private (confidential) information to the following person(s) and/or entity.
Name: All my treating providers at_____

Address: _____

City:_____ State:_____ Zip: _____

Phone Number:_____ Fax Number: _____

Information To Be Released

The information that can be obtained/disclosed under this authorization includes the following:

☐ Assessments/Evaluations
☐ Person Centered Plans/Treatment Plans
☐ Progress Note
☐ Psychological Test/Reports
☐ Psychiatric Evaluations/Medication Reviews/Labs
☐ Treatment/Service Recommendations
☐ Other:
☐ Educational/Developmental
☐ Discharge/Transfer Recommendations
☐ Information Related to Benefits or Insurance
☐ Work Related Information

Transmission Modes

The information may be released in:

☐ Written ☐ Verbal ☐ Electronic ☐ Photo ☐ Other: _____

Purpose of the Release:

☐ To provide comprehensive case coordination
☐ To determine eligibility for services
☐ At the request of the individual
☐ Other:

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Additional Information

Please note – The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

☐ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☐ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

I understand that:

-The requested information may not be protected from re-disclosures by the parties it is released to and is no longer protected under federal privacy laws; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulation (42 CFR part 2), the party this is disclosed to may not re-disclose such information without my further written authorization provided for by state or federal law.

- Substance Use Disorder related information can be released in the event of a bona-fide medical emergency without consent.
- Under 42 CFR Part 2, I have the right to request a list of disclosures to which disclosures have been made pursuant to the general designation
- For 42 CFR Part 2 violations, I can contact the US Attorney for Colorado at 1801 California Street, Suite 1600, Denver CO 80202, 1-303-454-0100
- Diversus Health has no control over this information after it is released and is not liable for any other disclosures.
- I may have a copy of this authorization.
- I may revoke this authorization at any time by notifying Diversus Health Medical Records in writing or by signing the revocation line of this form and returning it to Diversus Health Medical Records. Any revocation is for future releases and does not apply to any releases made prior to the revocation date.
- This authorization expires on_____or if left blank, two (2) years from my signature date.
- This authorization is not for the disclosure of psychotherapy notes, as Diversus Health does not maintain psychotherapy notes as part of the medical records.

Diversus Health Staff name: Date:

Client signature (12 years of age and over) Signature date

Client representative/Legal Guardian signature Signature date