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
☐ Other: _____
☐ Educational/Developmental
☐ Discharge/Transfer Recommendations
☐ Information Related to Benefits or Insurance
☐ Work Related Information
☐ Treatment/Service Recommendations

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

☐ Enrollment
☐ Attendance, hours and weeks completed
☐ Education/treatment levels
☐ Compliance with ancillary services
☐ Cooperation
☐ Treatment status and progress
☐ Fee payment
☐ Discharge status

Transmission Modes

The information may be released in:

☐ Electronic ☐ Written ☐ Verbal ☐ Photo ☐ Other _____

Purpose of the Release:

☐ To provide comprehensive care coordination
☐ At the request of the client/guardian
☐ To determine eligibility for services
☐ Other: _____

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

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:
Information disclosed based on this Authorization, except for information about a substance use disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. Diversus Health may not refuse to treat me if I refuse this Authorization unless this Authorization is necessary for my participation in a research study, or the purpose of the treatment is to provide information to the individual/entity identified in this Authorization.

Substance Use Disorder-related information can be released in the event of a bonafide 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 revoke (cancel) this authorization at any time by notifying Diversus Health Medical Records in writing or by signing the revocation form. If not revoked, this Authorization will expire two (2) years from the date I sign it unless a date is specified here_____.

This authorization is not for the disclosure of psychotherapy notes, as Diversus Health does not maintain psychotherapy notes as part of the medical records.

My signature below means I understand and accept the terms of this Authorization. A copy of this Authorization (including fax) is as valid as the original. I have a right to receive a copy of the signed Authorization.

Diversus Health Staff name: _____ Date: _____

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

Client representative/Legal Guardian signature _____ Signature date _____