Valley-Wide Health Systems, Inc.
Your Health, Our Priority!

FAX: 866-257-8195 (email: ICS@valley-widehealth.org)

Behavioral Health Authorization to Release and/or Exchange Protected Health Information

Patient Name:_____Date of Birth: _____
Street Address: _____City: _____
State: _____ Zip: _____ Phone Number: (____) _____

I hereby consent and authorize Valley-Wide Health Systems to:

☐ Obtain information from and/or

☐ Release private (confidential) information to the following person(s) and/or entity.

____Primary Physician Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____Social Security Administration Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___

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____Attorney Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____Social Services Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____School Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___

____Probation Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____Court Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____ Nursing Home/Residential Facility Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___

____ Victim Advocate Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____ Family Member(s) Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___
____ Emergency Contact Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___

____ Other Name: Phone: Fax: Date:	**Information to be Released:** ☐ Outpatient Treatment Report ☐ Laboratory and Pathology ☐ Mental Health Intake and Updated Assessment ☐ Peer Notes ☐ Psychiatric Medication Service Notes ☐ Discharge Summary ☐ Psychiatric Assessment ☐ UA/BA Results ☐ Case Management Notes ☐ Attendance ☐ Therapy Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Other: _____ ☐ Entire medical records Dates: _____ To: _____ **Purpose of Release:** ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other: _____ **Sensitive Information** - This information will not be released unless initialed by the patient. ☐ Crisis Treatment Summary ___ ☐ WMU Treatment Summary___ ☐ Substance and/or Alcohol Use___ ☐ TRT Treatment Summary___ ☐ ATU Treatment Summary___ ☐ HIV/AIDs Related Information___ ☐ Sexually Transmitted Disease___

Authorization:

Generally, laws prohibit a covered entity like Valley-Wide Health Systems from using or disclosing protected health information (PHI) unless authorized by individuals, except where this prohibition would result in unnecessary interference with access to quality healthcare or with certain other important public benefits or national priorities. Ready access to treatment and efficient payment for healthcare, both of which require use and disclosure of protected health information, are essential to the effective operation of the healthcare system. In addition, certain healthcare operations – such as administrative, financial, legal, and quality improvement activities – conducted by or for healthcare providers and health plans, are essential to support treatment and payment. To avoid interfering with an individual's access to quality healthcare or the efficient payment for such healthcare, the HIPAA Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and healthcare operations activities.

42 C.F.R. Part 2: I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations except in the instance of a bona-fide emergency. For 42 CFR Part 2 violations, Under 42 CFR Part 2, I have the right to request a list of disclosures which have been made pursuant to the general designation. I can contact the US Attorney for Colorado at 1801 California Street, Suite 1600, Denver CO 80202, 1-303-454-0100.

Redisclosure: I understand that information provided based on this Authorization may be re-disclosed to another party by the authorized recipient and that Valley-Wide has no control over the additional disclosure and cannot protect the information after it is released based on this Authorization. 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.

Right to Revoke: I understand that I may revoke this Authorization at any time by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions take or disclosures made while the authorization was in effect.

Conditioning: I understand that Valley-Wide may not condition healthcare treatment, payment, enrollment or eligibility for benefits on my executing this Authorization except for research purposes, for services conducted solely to produce information for a 3rd party, or enrollment in a health plan.

Psychotherapy Notes: The Authorization is not for a use or disclosure of psychotherapy notes as defined under HIPAA. Valley-Wide does not maintain psychotherapy notes as part of the medical record.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

This Authorization is valid for a one (1) year period. Each one (1) year period, clinician and/or case managers must receive written authorization to release information to complete services as planned. This Authorization will expire one (1) year from the date of my signature or on the date listed below (not to exceed two (2) years from today's date).

Date of Expiration: _____

☐ I understand that I am entitled to a copy of this authorization.

OTHER CONDITIONS:

A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Patient Name (Print): _____ Date: _____

Patient Signature: _____ Date: _____

Patient Representative/Legal Guardian (Print): _____ Date: _____

Patient Representative/Legal Guardian Signature: _____ Date: _____

CANCELLATION:

I understand that I may cancel this authorization at any time as noted in Valley-Wide's Notice of Privacy Practices, except when action has already been taken to obey it.

☐ I hereby revoke this Authorization to Disclose Information

I hereby cancel the authority of Valley-Wide to release information to:

_____

_____

Patient Signature: _____ Date: _____

Patient Representative/Legal Guardian Signature: _____ Date: _____

Notice to Recipient of Confidential Information

The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.