

Authorization to Release Confidential and Protected Health Information

Legal Name (please print) _____

Date of Birth _____

WellPower ID# _____

In accordance with federal rules, 42 CFR part 2 (Confidentiality of Substance Use Disorder Patient Records) and 45 CFR part 164 (Health Insurance Portability and Accountability Act of 1996), **I authorize the release of information about me as indicated below.** I understand information about any of the following may be included in the release: behavioral health, sexuality and reproductive health, HIV/AIDS, sickle cell anemia, communicable diseases, drug and alcohol use, and treatment for a substance use disorder.

<p align="center">WellPower</p> <p>4141 E. Dickenson Place Denver, CO 80222</p> <p>_____ P _____ F</p>	<p align="center">Third-Party</p> <p>Name: _____ (organization &/or individual)</p> <p>Relationship: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Additional: _____</p>
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Verbal Communication: Do you authorize two-way verbal (oral) communication between WellPower and Third-party? Yes No

Written or Electronic Records: WellPower is authorized to release records? Yes No
Third-party is authorized to release records? Yes No

Type of Information Authorized to be Released:

- All information maintained in my record, **OR**
- Only the types of information/records checked below (check all that apply):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Billing records | <input type="checkbox"/> Diagnosis list | <input type="checkbox"/> Employment info | <input type="checkbox"/> Physician summaries |
| <input type="checkbox"/> Clinical assessment(s) | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Laboratory results | <input type="checkbox"/> Progress summaries |
| <input type="checkbox"/> Continuity of care document (CCD) | <input type="checkbox"/> Education plan (IEP) | <input type="checkbox"/> Medication history/orders | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Demographics | <input type="checkbox"/> Education records | <input type="checkbox"/> Parole/Probation info | <input type="checkbox"/> Psychiatric evaluations |
| <input type="checkbox"/> Other (must specify): _____ | | | <input type="checkbox"/> Service/Treatment plans |

Time Period: (check only one)

- All admissions
- Most recent admission
- Dates _____ to _____

Purpose:

- Continuity of care
- Coordination of services
- Treatment
- At the request of the individual
- Other (must specify): _____

Re-disclosure

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).

Prohibition on Conditioning of Authorizations

I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. WellPower may not refuse to treat me if I refuse to sign 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.

Expiration and Right to Revoke (Cancel)

I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire two (2) years from the date I sign it unless an earlier date is specified here: _____.

Authorization

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

X _____ Signature of individual or personal representative _____ Signature date

Name of personal representative (if applicable) _____ Relationship

NOTICE TO RECIPIENTS

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). 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.