AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION & SUBSTANCE ABUSE TREATMENT RECORDS

GUNNISON VALLEY HEALTH
BEHAVIORAL HEALTH

Gunnison Valley Health Medical Records
711 N. Taylor St.
Gunnison, CO 81230

Phone: 970-641-7257 or 970-641-7252
Fax: 970-641-7273
Email: mr@gvh-colorado.org

For Provider

MRN #: _____

Patient Information

Patient Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** _____

Records Request

I request my records from:

☐ **Gunnison Valley Health Behavioral Health Department**

I request my records be sent to:

☐ **Self (Patient Only)** **Select method of release:** ☐ **Email** ☐ **Fax** ☐ **Mail** ☐ **Pick Up**

☐ **Other: Name of Facility, Other Person:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email** _____

I request my records to be released by the following method: ☐ **Email** ☐ **Fax** ☐ **Mail** ☐ **Pick Up**

Prior Dates of Service: ☐ **6 months** ☐ **12 months** ☐ **Specific Date — From:** _____ **To:** _____

☐ Prescriber Notes	☐ Care Plan	☐ Medications
☐ Psychotherapy Notes	☐ Discharge Summary	☐ STI/HIV/AIDS information and records
☐ Evaluation Notes	☐ Lab Results	☐ Billing Records
☐ Other (Specify):		

Purpose for Release

☐ Treatment / Further Medical Care ☐ Personal ☐ Insurance ☐ Legal ☐ Other: _____

Disclosers

Authorization for use and disclosure of mental health information:
State and federal laws govern the confidentiality and protection of individually identifiable health information. Except in specific situations defined in various laws, protected health information may not be disclosed without written authorization.

Authorization for use and disclosure of substance abuse information:
Substance abuse treatment records maintained by the Colorado Department of Human Services are confidential and will not be released, unless otherwise provided for by the regulations, without written consent from the individual or his or her personal representative.

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Notice Accompanying Disclosure Prohibition on Re-disclosure of Confidential Information.
This notice accompanies a disclosure of information concerning a patient in substance abuse treatment, made to you with the consent of such patient. This information will be disclosed from records protected by Federal confidentiality rules set forth in 42 CFR Part 2. The Federal rules prohibit any further disclosure of this information unless such further disclosure is expressly permitted by the written consent of the person to whom the records pertain 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. The Federal rules restrict any use of the information contained in these records to criminally investigate or prosecute any alcohol or drug abuse patient.

Revocation:
This authorization may be revoked at any time, in writing. If not revoked sooner, this authorization will expire upon discharge from treatment or one (1) year from the date it was signed, whichever first occurs. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided with a copy of this form.

Signature of Patient/Guardian/Authorized Representative* _____

Relationship _____ **Date** _____

Authorized Representative's Legal Authority:

- ☐ Medical Durable Power of Attorney Agent
- ☐ Guardian
- ☐ Conservator
- ☐ Healthcare Proxy Decision Maker
- ☐ Parent of Minor
- ☐ Surrogate Decision Maker for Healthcare Benefits
- ☐ Benefactor of Estate

*Signature by an authorized representative certifies that such person has the legal authority to authorize the disclosure on behalf of the patient.

Name of Staff Person Disclosing Records: _____ Date: _____ ☐Mailed ☐Faxed ☐Email ☐Pick Up