Designated Client Representative Authorization

I, ____ , hereby designate
(print name)

____ to be my (or my minor
(print name, and relationship if relevant)

child's) **Designated Client Representative (DCR).** My minor child's name is: ______________________.
(print name)

This means that my DCR has my permission to file a grievance or appeal on my behalf and to represent me in this process. I understand that I must still sign a Release of Information allowing:

- My DCR access to any protected health information, and
- Foothills Behavioral Health Partners (FBHP) or my treatment providers to discuss any aspects of my mental health services or treatment with my DCR

This designation of my DCR will remain in effect for one year from today's date, or until ______________, whichever is shorter. I may also revoke this authorization in writing at any time.

This DCR form also allows FBHP to share information with the State Department of Health Care Policy and Financing and with the State Office of Administrative Courts, if appropriate.

Contact information for my DCR is:

Address:____________________________ Phone Number(s):______________

____________________________ ______________

Signature:__________________________ Witness:________________________

Date: _________________________ Date : ________________________

Send completed form to:
Foothills Behavioral Health Partners
Office of Member and Family Affairs
9101 W. Harlan St., Suite 100,
Westminster, CO 80031

Rev. 6-19-15

Foothills Behavioral Health Partners
AUTHORIZATION TO RELEASE INFORMATION

Client's Name______________________________ ______/______/______ CID#__________
Last name, First name, Middle Initial- please print — Client's Birth Date

Family Member______________________________ Family Member______________________________

Family Member______________________________ Family Member______________________________

Address ______________________________ Phone (_____) ______________

City, State, Zip Code ______________________________ Fax (_____) ______________

I, ______________________________, ______________________________.
Client's name or name of person authorizing the release of information — State legal authority to sign for client, if applicable

Request for information to be exchanged between Foothills Behavioral Health and the following:

☐ To

☐ From

Name of Director/Hospital/Person/Agency: ______________________________

Address: ______________________________ Fax #: ______________

City: ______________ State ______________ Zip ______________ Phone

Specify purpose for **Authorization** ______________________________

- **I authorize the following information to be released:**

☐ Opening summary
☐ Treatment Plan
☐ Drug or Alcohol Abuse
☐ Psychiatric and/or Medical History
☐ Final Diagnosis
☐ Summary of Treatment Progress
☐ Closing Summary
☐ Discharge Summary - Hospital
☐ Progress-to-Date Forms
☐ Other______________________________
☐ Physician Progress-to-Date Forms
☐ Medication, Prescriptions and Diagnostic Information
☐ Status of Attendance & Involvement in Treatment
☐ Autoimmune Deficiency (AIDS) information

- If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42, C.F.R. Part 2.
- I understand that there is potential for information disclosed, as a result of this authorization, to be redisclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.
- I understand that I may revoke this release/authorization at any time by giving written notice to Foothills Behavioral Health Partners, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on _____/_____/_____ (date), or if left blank, one year from the date of my signature, or as of the action or event of ______________________________.
- I understand that I have a right to refuse to sign this Authorization form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

______________________________ ______________________________ _____/_____/_____
Signature of Consumer/Parent/Legal Representative — Relationship to Consumer — Date

______________ ______________ ______________ ______________
Family Member — Family Member — Family Member — Family Member

I hereby revoke this Authorization to Release Information: ______________________________ _____/_____/_____
Client Signature — Date