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

- 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

Foothills Behavioral Health 9101 Harlan Street, Suite 100, Westminster, CO 80031 (303)-432-5950 FAX: 303-432-5970