CENTENNIAL PEAKS HOSPITAL

2255 South 88th St. Louisville, Colorado 80027
Phone 303-673-9990 Fax 303-666-2097

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Purpose: Verbal or Written exchange of information while you are in a CPH program, Written information only after discharge from a CPH program either with a healthcare provider or other involved person as named below.

Patient Name:_____ **Date of Birth:**_____ **Phone #:**_____
(Please print)

I authorize:	**To Release to:**
Centennial Peaks Hospital **Name of Person or Entity**	_____ **Name of Person or Entity**
2255 South 88th Street **Address**	_____ **Address**
Louisville, CO 80027 **City**	_____ **City**
Phone # **Fax #**	**Phone #** **Fax #**

****My initials signify that I consent for the following type(s) of information to be released to the above individual/entity.**
_____ Drug/Alcohol Abuse, Psychiatric conditions, Medical conditions, HIV or AIDs related information

Do **not** release the following:_____

Treatment Dates: _____

Information that may be released:
☐**Medication Record** ☐**Physician's Admission Assessment**
☐**History and Physical Exam Report** ☐**Lab Results** ☐**ECT**
☐**Discharge Plan/Continuing Care Plan** ☐**Discharge Summary**
Other assessments: ☐**Psychosocial** ☐**Intake** ☐**Other (specify)** _____

***PURPOSE FOR WHICH INFORMATION IS TO BE USED:**
___ Continuing Care ___ School ___ Disability benefits
___ Legal ___ Personal ___ Employment conditions

***If for legal purposes, give specific reason: (must be completed)**_____

AUTHORIZATION:
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:
This information has been disclosed to you from records whose confidentiality may be protected by Federal Law:
"Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 to criminally investigate or prosecute any alcohol or drug abuse patient." [RM 203, 7.2] Rev. 4-12-04
This consent expires one year from the date below unless otherwise specified: (cannot exceed one year)_____

Patients age 14 and younger require parent/guardian signature only; Patients age 15-17 require signature of both patient and parent/guardian; patients age 18 and older must sign exclusively unless there is a legal guardian.

_____ _____ _____ _____
Signature of Patient **Date** **Signature of Parent/Guardian, if applicable** **Date**

_____ _____
Witness, if applicable **Date**

Revocation: I hereby revoke the above authorization: Signature_____***Date***_____
Staff Witness: (required) _____ ***Date:***_____

Please read the following for information regarding Release of Information.

1. **Centennial Peaks Hospital (CPH) will act upon a properly completed request within 7-10 business days. If the chart is in storage, a delay may be encountered. If the request cannot be fulfilled, the requestor will be notified.**
2. **The minimum necessary for the stated purpose shall be requested.**
3. **There is a charge for copies to be sent, unless the information is going to a continuing care provider for the purpose of continuing care. Charges for copies of records are regulated by State law (C.C.R. 1011-1, Chapter 2, Part 5.2.3.4), and are as follows: $14.00 for the first ten (10) or fewer pages, $0.50 per page for pages 11-40, and $0.33 per page thereafter, plus postage.**
4. **CPH recommends that requests for Attorneys, Insurance Companies, Social Security Disability Offices, and the like come directly from the entity to receive the request. This prevents delays.**
5. **This authorization is voluntary and may be revoked at any time, except in the event that the request has already been completed by CPH or its designee. Revocation must be in writing as provided for on this form or in letter format (written).**
6. **Patients 15 years of age and up may seek treatment on their own at this facility, thus, we require authorization. Please see the physician if there is a problem.**
7. **Those entities receiving health information are informed not to re-disclose confidential health information, however, once a request is completed CPH has no control over how the information is used or disseminated. Confidentiality of alcohol and drug abuse health records is protected by Federal Law. By authorizing this request to release health information, the undersigned releases the above parties from any liability which may result from furnishing the information released or requested.**
8. **Refer to the Notice for Privacy Practices regarding authorized disclosures.**

(If Centennial Peaks Hospital has asked for this authorization, the patient receives a copy of the authorization)