



## Client Release of Information / Authorization for Use and Disclosure

Client First & Last Name: \_\_\_\_\_ Client Date of Birth: \_\_\_\_\_  
Today's Date: \_\_\_\_\_ Status: ☐ Active ☐ Revoke  
☐ Void ☐ Client Declined

As a Health Solutions West client, I understand that state and federal regulations govern the confidentiality and protection of my individually identifiable health information (CFR 42 Part 2, CRS 25.1, HIPAA). Except in situations legally required or permitted, information about me cannot be disclosed to persons or agencies outside Health Solutions West, Inc. without my written permission. I understand that additional protections exist for substance abuse information and for HIV/AIDS information.

**I hereby authorize Health Solutions West, Inc. to send, receive, exchange, use or disclose health information about me to:**

One (1) form per authorization is required.

Third Party Relationship to Client: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Agency: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State: \_\_\_\_\_

I consent to release the following types of information listed: (Please mark all that apply)

<input type="checkbox"/> All Substance Use Information	<input type="checkbox"/> Diagnostic Assessment
<input type="checkbox"/> HIV/AIDS Information	<input type="checkbox"/> Legal Information
<input type="checkbox"/> Medical/Lab Information	<input type="checkbox"/> Medication Management/Progress Notes
<input type="checkbox"/> Payment/Balance Related Information	<input type="checkbox"/> Psychiatric Evaluations
<input type="checkbox"/> Psychological/Neurological Testing	<input type="checkbox"/> Social History/Background
<input type="checkbox"/> Update and/or Discharge Summaries	<input type="checkbox"/> Other (please specify) _____

**Purpose:** (Must select at least one)

- ☐ Continuity of Care  
☐ Coordination of Services  
☐ Treatment  
☐ At the Request of the Individual  
☐ Other (please specify) \_\_\_\_\_

Health Solutions West  
515 28 3/4 Road  
Grand Junction, CO 81501  
Medical Records Department  
Phone: (970) 683-7252  
Fax: (970) 683-7055

### 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. Health Solutions West 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 in two (2) years from the date I sign it unless an earlier date is specified here:

Expiration Date: \_\_\_\_\_

Client or Representative Signature

Date

If Representative, Relationship to Client

Witness Name: \_\_\_\_\_

Revised:  
4/2025