HEALTH SOLUTIONS WEST
515 28 ¾ Rd Grand Junction, CO 81501
P: 970.683.7252 F: 970.683.7055

Authorization for Use and Disclosure of Client Information

As a Health Solutions client, I understand my treatment records, to include any medical, behavioral and/or substance records, are protected under federal law, including 42 CFR Part2 and HIPAA, and any applicable state laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state laws. This authorization permits disclosure to individual(s), organization(s), or class of recipients listed below and, unless otherwise limited by me, permits disclosure to HIPAA-covered entities and business associates for purposes of treatment, payment, and health care operations (TPO).

Client Information:

Full Legal Name: _____ Prior Name(s): _____
Date of Birth: _____ Current Phone #: _____
Mailing Address: _____ Email:_____
City: _____ State: _____ Zip Code: _____

Authorization to Release Information: I authorize Health Solutions and the person(s) or organization(s) listed below to send, receive, and exchange my health information as described in this authorization. This authorization allows two-way communication between Health Solutions and the listed party.

To be released to/from:

Name: _____ Agency/Organization: _____
Relationship (if applicable):_____ Telephone: _____ Fax: _____
Mailing Address: _____ Email:_____
City: _____ State: _____ Zip Code: _____

Information to be disclosed (Select all that apply):

☐ Continuity/Transition of Care Packet ☐ Lab/Diagnostic Reports ☐ Discharge Summary ☐ Physician Orders
☐ History and Physical ☐ HIV/AIDS results and treatment ☐ Psychiatric Evaluations ☐ Progress Notes
☐ Other: _____
☐ SUD Counseling Notes: I specifically authorize the use and disclosure of my substance use disorder (SUD) counseling notes. A Part 2 program may not require me to check this box as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. SUD Counseling notes may contain detailed information, including but not limited to conversational content, analysis, information about the client's emotional/cognitive state, and specific risks.

Information to be released for the following purposes (Must select at least one):

☐ Additional Evaluation or Treatment ☐ Client Request ☐ Continuity of Care ☐ Legal Proceedings
☐ Multi-Agency Coordination ☐ Service Planning ☐ Professional Consultation ☐ Report to court/other agency
☐ Representative/Guardian Request ☐Obtaining Client Resources/Benefits ☐Treatment, Payment or Healthcare Operations
☐ Other: _____

Client Rights: I do not have to sign this document to get treatment at Health Solutions unless treatment is required by a court or another official; I have the right to revoke this authorization in writing; Some information about me may be given out without my consent if the law allows it (see Notice of Privacy Practices); Copies of this form may be used in place of the original; Signatures received by fax will be accepted; Health Solutions cannot promise that people who get this information will keep it private. They may or may not have to follow the privacy laws; I understand that I am entitled to a copy of this authorization; This authorization form applies to all Health Solutions programs and locations, including behavioral health and primary care; SUD Counseling and Psychotherapy Notes may be released at the discretion of the provider. **Redisclosure Notice:** I understand that if HIPAA and 42 CFR Part 2 covered entities and business associates receive these records for treatment, payment, and healthcare operations purposes, the records may be redisclosed in accordance with HIPAA and 42 CFR Part 2, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.

This Authorization will expire (2) years from the date I sign it unless an earlier date is specified here: Expiration Date:_____

_____ _____ _____
Client or Legal Representative Printed Name
(if Legal Representative must provide relationship to client)
Client or Legal Representative Signature
Date Signed

_____ _____
Revocation Signature
Date of Revocation