HIPAA FORM #1-A

Supplemental Authorization for the Release of Information

(for alcohol/drug treatment, psychological/psychiatric conditions/notes, and HIV/AIDS records)

I,_____(PRINT NAME), born on_____(DATE OF BIRTH), hereby authorize Boulder County Public Health (BCPH) to release and exchange the information I have specified below, including protected health information (PHI), to and with

_____

(NAME OF PERSON/PROGRAM/AGENCY RELEASING and/or RECEIVING INFORMATION WITH BCPH)

I hereby authorize the release of information regarding the following conditions *(please initial the appropriate items):*

_____Drug Abuse _____Alcohol Abuse _____Psychological or Psychiatric Conditions/Notes _____HIV/AIDS

Information to be Released and/or Obtained:

( ) Yes ( ) No Alcohol/Drug Recommendations

( ) Yes ( ) No Diagnosis

( ) Yes ( ) No Discharge Summary

( ) Yes ( ) No Complete Medical Records

( ) Yes ( ) No Psychological/Psychiatric Testing/Evaluation

( ) Yes ( ) No Summary of Treatment/Recommendations

( ) Yes ( ) No Urinalysis (UA)/Breathalyzer (BA) Results

( ) Yes ( ) No Other:_____

Purpose of Release:

( ) Yes ( ) No At Request of Patient

( ) Yes ( ) No Assessment

( ) Yes ( ) No Continuity of Care

( ) Yes ( ) No Service Planning

( ) Yes ( ) No Compliance with Court-Ordered Treatment

( ) Yes ( ) No Other:_____

NOTICE TO RECIPIENT

- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2).
- The federal rules prohibit 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 42 CFR Part 2.
- A general authorization for release of information is NOT sufficient for this purpose.
- The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.

EXPIRATION OR REVOCATION OF AUTHORIZATION

- I understand that the authorizations I have requested in this form will automatically expire 365 days from the date that I sign the form below (under "Agreements").
- I understand that if I want to revoke (i.e. terminate) any of the authorizations that I've requested on this form BEFORE the 365-day expiration date listed above or any other date provided, I will need to complete *BCPH HIPAA Form #3, Request from Client Revoke Authorization to Release or Disclose Protected Health Information (PHI)*, which I can request from any BCPH HIPAA program or BCPH's HIPAA Privacy Official (see contact information below), **OR** I can contact the HIPAA Privacy Official (below) and verbally request revocation of my authorization.
- I understand that if I choose to complete *BCPH HIPAA Form #3, Request from Client to Revoke Authorization to Release or Disclose Protected Health Information (PHI)*, the form must be returned to BCPH's Privacy Official at the address below:

Boulder County Public Health
ATTN: HIPAA Privacy Official
3450 Broadway
Boulder, CO 80304
Phone: 303-441-1141
FAX: 303-441-1452

AGREEMENTS

- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality and drug abuse patient records (i.e. 42 CFR [Code of Federal Regulations] Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I understand that 45 CFR Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I understand that this consent is valid for no longer than the period of time necessary to carry out the stated purpose of the request for information unless otherwise noted below, and that I may revoke the consent at any time by following the procedures outlined above ("Expiration or Revocation of Authority") unless action has been taken in reliance upon it and unless I am participating in the program as a formal condition of probation, parole, or release of confinement, in which case the consent cannot be revoked until there is a formal termination or revocation of release from confinement, probation, or parole.
- I understand that, generally, I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to receive treatment or payment or my eligibility for benefits, but that in certain limited circumstances, I may be denied treatment if I do not sign this form.
- I understand that I may inspect or copy any information used and/or disclosed under this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed (if allowed by law) and no longer protected by these regulations.
- I understand that BCPH may need to charge me for reasonable clerical costs for making my records available for inspection.
- I understand that I may receive a copy of this Authorization, if requested.

Client Signature:_____ Date:_____

PRINTED CLIENT NAME:_____

If you are NOT the client listed above, please complete the following (PLEASE PRINT):

What is your relationship to the client?

☐ Parent or guardian of the client, who is a minor

☐ Guardian or conservator of the client, who is incompetent

☐ Beneficiary or personal representative of the client, who is deceased

☐ Other – please specify:_____

Your Name:	Date of Birth:
Address:	
City/State/Zip:	E-Mail:
Daytime Phone:	Evening Phone:

Signature of Client Representative Making Request:_____ Date:_____

Instructions for submitting this form:

Please complete and return this form ALONG with BCPH HIPAA Form #1, *Authorization from Client for the Release or Disclosure of Protected Health Information (PHI)* to the Boulder County Public Health HIPAA program from which you're making this request, OR you can submit the form to BCPH's HIPAA Privacy Official at the following address:

Boulder County Public Health
ATTN: HIPAA Privacy Official
3450 Broadway, Boulder, CO 80304
Phone: 303-441-1141
FAX: 303-441-1452