Amie R. Bryant, LCSW, CAC III
Four Corners Counseling, LLC

AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

Client Name _____ Date of Birth _____

I understand there are Colorado and Federal guidelines about my right to 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 released to persons or agencies outside the treatment team without my written permission. Additional protections exist for substance abuse information and for HIV/AIDS status. I hereby authorize Four Corners Counseling and its providers to **send, receive, exchange, use or disclose health information about me to:**

Name/Address/Phone of persons or organizations to receive/release the information:

_____

_____

Particular information to be used or disclosed includes:

___ Assessment, diagnosis
___ Medication assessments, records
___ Update or discharge summaries
___ Social history, background
___ Substance abuse data
___ Evaluations or testing
___ Legal information
___ HIV/AIDS status
___ Education information
___ Medical/lab information
___ Other (specify)_____

The information to be released will be used for the following purposes:

___ Continuity of care
___ Service planning
___ Professional consultation
___Obtaining basic needs or benefits for the client
___ At the request of the client/personal representative
___ Additional evaluation or treatment
___ Multi-agency coordination
___ Treatment, payment or healthcare operations
___ Vocational service/Voc. Rehabilitation
___ Other (specify)_____

Other important information:

1. My treatment by Four Corners Counseling does not depend on signing this authorization unless a court or other authorized third party requires treatment. Some disclosures may be made without my consent if legally permitted or required (see Notice of Privacy Practices for more information).
2. This authorization will expire in one year unless my treatment ends or I revoke it in writing. I may revoke my authorization at any time. Four Corners Counseling cannot take back any information disclosed before I revoked the authorization.
3. Copies of this form may be used in lieu of the original. Signatures received by fax will be accepted.
4. Four Corners Counseling cannot guarantee that recipients of information disclosed through this authorization will not re-disclose it to another party. The recipient may or may not be subject to federal laws protecting health information. If the disclosure concerns substance abuse or HIV/AIDS information, the recipient is not permitted to re-release it to anyone.

_____ _____
Client signature Date Witness Signature

_____ _____
Representative Signature If representative, give relation to client

Four Corners Counseling, LLC. frequently uses **email to communicate**. Please be aware that electronic mail is not a completely confidential means of communication. I give my permission to communicate information about me through electronic mail.

_____ _____
Client signature Date Witness Signature

I **RENEW THIS AUTHORIZATION** FOR USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR ANOTHER 365 DAYS

_____ _____
Client signature Date Witness Signature

_____ _____
Representative Signature If representative, give relation to client

REVOCATION: I revoke my authorization for this use and disclosure of my health information.

_____ _____
Client/representative signature Date