Mesa County Criminal Justice Services Department
Administration located at 636 South Avenue, Grand Junction, PO Box 20,000, 81501

Authorization for Use and Release of Protected Health/Treatment Information

I, _____, (Name), hereby authorize the use and release of my health and/or treatment information as described in this authorization; my health and/or treatment information is protected by the federal regulations implementing the Health Insurance Portability and Accountability Act (HIPAA).

Part I: Disclosure Designation

Please identify the specific division within Mesa County Criminal Justice Services authorized to disclose the information

____Mesa County Community Corrections ____ Summit View Treatment Services ____ Community Based Services

Specific person and/or organization authorized to receive/use the information, including address:

_____
_____
_____

___ I authorize my information and records to be transmitted electronically to the email address I listed above.

Purpose of the request: (Reason for requesting records disclosure.)

_____
_____
_____

Part II: Information Authorized for Disclosure

1 Substance Abuse Treatment Information: _____ Client Initial

My initials indicate I authorized disclosure of my Substance Abuse Treatment Information as follows
(Specific and meaningful description of information to release. For example: substance use evaluation reports, drug testing results used for treatment, treatment progress reports, and substance use screenings/assessments. At minimum, please include specific document types, case numbers, program names and dates or date ranges).

_____
_____
_____

I understand that Substance Abuse Information requires a separate authorization as defined in the federal regulations (42 CFR Part 2) implementing HIPAA and I am specifically authorizing the release of such records and information as described by signing below:

_____ _____
Client Signature Date

2 Other Behavioral Health Information: _____ Client Initial

Other Behavioral Health information may include sex offender supervision and treatment information, domestic violence treatment information, anger management treatment information, cognitive restructuring and other psycho-educational treatment information.

My initials indicate I authorize disclosure of my other protected health information which is not related to substance use treatment or other behavioral health treatment, as follows:
(Specific and meaningful description of information to release. Treatment Progress Reports recorded by a mental health professional documenting or analyzing the contents of conversation by progress reports or certificates of completion. Please include specific document types, case numbers, program names and dates or date ranges).

_____
_____
_____

I understand that treatment information require a separate authorization as defined in the federal regulations (45 CFR Part 164) implementing HIPAA and I am specifically authorizing the release of such records and information as described by signing below. I understand that I do not have a right to access Treatment information and my request for disclosure may be denied (See 45 CFR 164.524)

_____ _____
Client Signature Date

3 Other Mental Health Protected Information: _____ Client Initial

My initials indicate I authorized disclosure of my Other Protected Health Information which is not related to substance abuse treatment or other behavioral health treatment and/or information, as follows:
(Specific and meaningful description of information. For example: mental health evaluation reports, mental health treatment plans, mental health progress reports, mental health screenings and assessments, medical screening and medication monitoring records. Please include specific document types, case numbers, program names and dates or date ranges).

_____
_____
_____

I am authorizing the release of my Protected Health Information as described by signing below.

_____ _____
Client Signature Date

Part III: Acknowledgements

Right to Revoke: I understand that I have the right to revoke this authorization at any time in writing to:
Attention: Records Custodian
Mesa County Criminal Justice Services
636 South Avenue, Grand Junction, CO 81501

1. I understand that the revocation is only effective after it is received and logged. I understand that any use or disclosure made prior to the revocation will not be affected by a revocation.
2. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.
3. I understand that my initial and continued participation in Criminal Justice Services programs may be subject to my agreement to this authorization.
4. I understand I am entitled to receive a copy of this authorization.
5. I understand that this authorization will either expire when my supervision terminates or if not currently involved with the program, this authorization will expire twelve (12) months from the date of my signature below.
6. Summit View will ONLY release information or documentation generated by Summit View. Information or documentation from other agencies such as referral agencies, treatment providers, or medical agencies will not be released by Summit View. Persons or agencies requesting such information will be directed to the person or agency that generated the information or documentation.

_____ _____
Printed Client Name Date of Birth

_____ _____
Client Signature Date

_____ _____
Staff Signature Date