SUMMIT COMMUNITY
CARE CLINIC

RECORDS AND INFORMATION RELEASE AUTHORIZATION

I authorize the disclosure of my protected health information as follows:

FROM: SUMMIT COMMUNITY CARE CLINIC
P.O. Box 4337
Frisco, CO 80443
(970) 668-4040 / fax (970) 668-6699

TO: _____
_____
_____

FROM: _____
_____
_____

TO: SUMMIT COMMUNITY CARE CLINIC
P.O. Box 4337
Frisco, CO 80443
(970) 668-4040 / fax (970) 668-6699

Please initial by all types of Information you wish to be released:

_____ Provider visit notes (*these office notes may include Mental health, Substance abuse, HIV info*)
_____ Drug/alcohol information
_____ Laboratory reports
_____ X-ray reports
_____ HIV/AIDS or other STD information
_____ Mental health, psychiatric, or behavioral health services
_____Permission to exchange verbal/written information
_____ Other (Specify) _____

Covering the period of health care: **From**: _____ **To:** _____

My Name: _____ Other Names I Have Used: _____

My Birthdate: _____ My Social Security Number: _____

Home Phone: _____ Work Phone: _____ Other Phone_____

I understand that once this information is disclosed, it may not be protected by Federal privacy regulations. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this form. I understand that I may take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it, and that this must be in writing and be given to the HIPAA Privacy Officer or Patient Services Supervisor. I understand that this consent will expire 180 days from the date of my signature unless cancelled as above or an expiration date is noted here: ___/____/___.

The records being released are protected under 42 C. F. R. Part 2, governing Alcohol and Drug Abuse patient records. Federal Law prohibits any further disclosure of such records without specific written consent of the person to whom it pertains or when otherwise permitted by such regulation. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If I have any questions about this disclosure, I can contact the Office Manager at (970)-668-4040.

Signature: _____
Date:_____

Print name and relationship to patient if not patient:
_____

Witness: _____ **Print Name:** _____ **Date:** _____

Date Request Received: _____ Date of Release: _____ Initials: _____