summit community CARE CLINIC

Summit Community Care Clinic
Authorization for Use and Disclosure of Behavioral Health Information

360 Peak One Drive, Suite 100
Post Office Box 4337 Frisco, CO 80443
Phone: (970) 668-4040
Fax: (970) 668-6699

Patient's name: _____ Previous name: _____

Date of birth: _____ Last 4 of social: __ __ __ __ Phone number: (_____) _____-_____

Mailing address: PO BOX: _____ Physical: _____

City: _____ State: _____ Zip: _____

My Authorization

I UNDERSTAND THAT STATE AND FEDERAL REGULATIONS GOVERN THE CONFIDENTIALITY AND PROTECTION OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (CFR 42 PART 2, CRS 25. 1 HIPAA) 42 CFR PART 2 SPECIFICALLY PROTECTS CONFIDENTIAL INFORMATION ABOUT DRUG AND ALCOHOL SUBSTANCE ABUSE TREATMENT. I HEREBY AUTHORIZE SCCC TO USE OR DISCLOSE HEALTH INFORMATION ABOUT ME.

You may use or disclose the following health care information (initial those you are requesting):

____Mental Health assessment / diagnosis
____Psychiatric notes
____Substance abuse information
____HIV/AIDS Information
____Other:_____
____Evaluation or testing results
____Medication assessments
____Updates, discharge summary
____Social history/background

The disclosed information will be used for the following purposes:

____At the request of the patient
____Evaluation purposes
____Obtaining services for the patient
____Treatment, payment of healthcare operations
____Continuity of care
____Multi-agency coordination of care
____Reports to courts or other agencies
____Other: _____

You may disclose this health information to / from:

Name (or title) of organization/facility: _____

Attention: _____Address:_____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship to patient

_____ _____
Name/Signature of Witness Date

MY ABILITY TO OBTAIN SERVICES AT SCCC DOES NOT DEPEND ON SIGNING THIS AUTHORIZATION FORM UNLESS A COURT OR AUTHORIZED THIRD PARTY HAS REQUIRED MY TREATMENT. I UNDERSTAND THAT CERTAIN DISCLOSURES MAY BE MADE WITHOUT MY PERMISSION AS DESCRIBED IN SCCC'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND COPIES OF THIS FORM MAY BE USED IN LIEU OF THE ORIGINAL AND THAT SIGNATURES RECEIVED BY FAX WILL BE ACCEPTED. SCCC CANNOT GUARANTEE THAT RECIPIENTS OF THE INFORMATION DISCLOSED THROUGH THIS AUTHOIZATION WILL NOT RE-DISCLOSE TO ANOTHER PARTY. I UNDERSTAND THAT THE RECIPIENT MAY OR MAY NOT BE SUBJECT TO FEDERAL LAWS PROTECTING HEALTH INFORMATION. I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME, IN WRITING. IF NOT REVOKED, I UNDERSTAND THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR OR SIX MONTHS AFTER LAST DATE OF SERVICE, WHICHEVER IS SOONER.

Interpreter's Statement I have orally translated and explained the contents of the information on this form to the patient in a language they understand. To the best of my knowledge and belief, they understand this explanation and voluntarily consent to the release of records determined above.
Interpreter's Signature: _____ Date: _____

Records will be released within 10 business days. If you have an urgent situation, please notify a staff member.

OFFICE USE ONLY Initials of personnel releasing: _____ Date: _____ **Circle**: Faxed / Mailed / Delivered In-Person