Authorization for Release of Protected Health Information

Today's Date:	Legal Name:
Date of Birth:	Address:
Phone Number:	

As a Frontier Psychiatry patient, I understand that state and federal regulations govern the confidentiality and protection of identifiable health information (CFR 42 Part 2, CRS 25.1, HIPAA). Except in situations legally required or permitted, information about me cannot be disclosed to persons or agencies outside of Frontier Psychiatry without my written permission. I understand that additional protections exist for substance abuse information and for HIV/AIDS information.

I consent to release the following types of information listed: (please mark all that apply)

☐ Psychiatric Evaluation	☐ Medication Management/Progress Notes
☐ Social History/Background	☐ Psychological/Neurological Testing
☐ Medical/Lab Information	☐ All Substance Use Information
☐ Update and/or Discharge Summaries	☐ Diagnostic Assessments
☐ Legal Information	☐ Billing/Payment History
☐ HIV/AIDS Information	☐ Other:

I hereby authorize Frontier Psychiatry to send, receive, exchange, use or disclose health information about me to:

One (1) form per authorization is required.

Facility:	Contact Name:
Address:	City/State:
Phone Number:	Fax Number:

Authorization:

I understand that the information to be released might include information regarding treatment of mental health, alcohol and drug usage, HIV and AIDS related information.

Re-disclosure:

I understand that information disclosed based on this Authorization, except for information about a substance use

disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

Prohibition on Conditioning of Authorizations:

I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. Frontier Psychiatry may not refuse to treat me if I refuse to sign this Authorization.

Expiration and Right to Revoke (Cancel):

I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire in one year from the date I sign it unless an earlier date is specified here

Expiration Date:

Client or Representative Signature If Representative, Relationship to Client Witness

Printed Name:
Signature:

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