Jefferson Hills
Release of Information or Authorization

Child/Youth's Name (Last, First, MI) **Please Print** _____ Child/Youth's Date of Birth (MM/DD/YYYY) _____

Address, City, State, Zip _____ Phone _____

I, _____ _____
Child/Youth's Name **(Please Print)** Parent/Legal Guardian Name **(Please Print)**

Request information to be exchanged between Jefferson Hills (JH) and the following:

☐ To JH Name of Doctor/Hospital/Person/Agency: _____
☐ From JH Address: _____
City, State, Zip: _____ Phone: _____
Email Address: _____ Fax: _____

JH Staff check only one box to indicate the purpose for which the information is to be released/authorized:

☐ **JH Treatment, Payment, or Operations** (specify purpose for **Release**): _____
☐ **Other** (specify purpose for **Authorization**): _____

- **I understand that information to be released/authorized may include information regarding the following condition(s):**
  - (x) Drug Abuse
  - (x) Alcoholism or Alcohol Abuse
  - (x) Assessment, including Diagnosis
  - (x) Medical Information/Medications Prescribed
  - (x) Educational Information
  - (x) Psychiatric Conditions/Treatment/Psychological Testing
  - (x) HIV/Auto Immune Deficiency Syndrome (AIDS)
  - (x) Treatment Summary, Recommendations, Consultation
  - (x) Service Plans
  - (x) Other: _____
- **I understand that if this is a Release for "Treatment, Payment and Operations" (TPO) purposes, Jefferson Hills may withhold treatment, payment, enrollment, or eligibility for benefits if I refuse to sign.**
- **I understand that if this is an Authorization for "Other" purposes, Jefferson Hills *may* condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign or not. However, Authorization to Release protected information may be a requirement of the court, a probation department, Department of Human Services, or the Department of Corrections, which may refuse parole, probation, or placement according to their organizational policies.**
- If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Regulation 42, C.F.R Part 2. *Initial Here:* _____
- I understand that there is potential for information disclosed, as a result of this release/authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.
- I understand that I may revoke this release/authorization at any time by giving written notice to Jefferson Hills, except to the extent that action has already been taken to comply with it. Without such revocation, this Release/Authorization will expire on _____.
- I understand that I have a right to refuse to sign this Release/Authorization form subject to the conditions notes above, or if I sign, I am entitled to a copy of the signed forms.

Child/Youth's **Signature** _____ Date _____

Parent/Legal Guardian **Signature** _____ Date _____

Staff Witness **Signature** _____ Date _____

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. If applicable, a minimum necessary determination has been applied to this release/authorization. If you have any questions concerning this release/authorization, please call 303.989.4357. Please send all information/correspondence to:

Jefferson Hills, Attn: Medical Records, 421 Zang Street, Lakewood, CO 80228.

I hereby revoke consent of this Release of Information or Authorization.

Child/Youth's **Signature** _____ Date _____

Parent/Legal Guardian **Signature** _____ Date _____

Staff Witness **Signature** _____ Date _____