Red Stone Counseling, LLC
80 Garden Center, Suite 152
Broomfield, CO 80020

Authorization to Release Protected Health Information

Patient Name:______________________________**Date of Birth:**________________**Phone #:**____________________
(Please print)

I authorize release (Please Circle One) **To / From:** Red Stone Counseling, LLC 80 Garden Center, Suite 152 Broomfield, CO 80020 Phone: (303) 481-3491	(Please Circle One) **To / From:** ____ Name of Person or Entity ____ Address ____ City and State Phone # Fax #

My *initials* below signify that I consent for the following type(s) of information to be released to the above individual/entity.
_____ Substance Use Disorder Information______Psychiatric conditions _____ HIV or AIDs related information _____Medical conditions

Do **not** release the following:____

Treatment Dates: ___________________________________

Information that may be released:

- ☐ **Discharge Summary**
- ☐ **History and Physical Exam Report**
- ☐ **Discharge Plan/Continuing Care Plan**
- ☐ **Substance Abuse/Use Documentation**
- ☐ **Verbal Exchange**
- ☐ **Physician's Psychiatric Evaluation**
- ☐ **Lab Results**
- ☐ **Psychosocial Assessment**
- ☐ **Other (specify)**_________________________
- ☐ **Physician's Progress Notes**
- ☐ **Medication Record**
- ☐ **Intake Assessment**
- ☐ **Entire Record**

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

___ Continuing Care/Treatment/Care Coordination
___School
___Personal
___Disability Determination/Benefits
___Employment conditions
___Payment/Billing
___Healthcare Operations
___ Legal ___Other

If for legal purposes, give specific reason: (must be completed)____

AUTHORIZATION:
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original. Any information protected by Federal Regulations governing confidentiality of substance use disorder patient records (42 CFR Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. Business is not liable for such re-disclosures.

This consent expires one (1) year from the date belowunless otherwise specified: ____

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Signature of Patient (15 years and older) **Date** **Signature of Parent/Guardian, if applicable** **Date**

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Witness, if applicable **Date**

Revocation: I hereby revoke the above authorization: Signature________________________________***Date***__________