Divine Health Group

Authorization for Release of Information

Name: Date of Birth:

I request and authorize Divine Health Group to release or request information specified below to the organization, agency or individual named on this request. This section of the form may be used as a multi-agency release of information. I authorize Divine Health Group to release information to and obtain information from the following agencies and/or individuals:

Name: _____
Relation: _____
Phone Number: _____

Name: _____
Relation: _____
Phone Number: _____

Name: _____
Relation: _____
Phone Number: _____

Name: _____
Relation: _____
Phone Number: _____

AUTHORIZATION:

Generally, these laws prohibit a covered entity like DHG from using or disclosing PHI unless authorized by individuals, except where this prohibition would result in unnecessary interference with access to quality healthcare or with certain other important public benefits or national priorities. Ready access to treatment and efficient payment for healthcare, both of which require use and disclosure of protected health information, are essential to the effective operation of the healthcare system. In addition, certain healthcare operations – such as administrative, financial, legal, and quality improvement activities – conducted by or for healthcare providers and health plans, are essential to support treatment and payment. To avoid interfering with an individual's access to quality healthcare or the efficient payment for such healthcare, the HIPAA Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and healthcare operations activities.

I understand the following Regional Accountable Entities (RAEs) are authorized to receive and re-disclose necessary health and treatment information that includes, but is not limited to medical, mental health, and substance use disorder for the purpose of processing a claim for services: Rocky Mountain Health Plans, Northeast Health Partners, Colorado Access, Health Colorado, Inc., Colorado Community Health Alliance, Signal Behavioral Health Network, and Credit Service Company Inc. I hereby release these parties from any legal responsibility which may result from furnishing the information released or requested.

Further Discloser:

Information disclosed for payment and reporting may be further disclosed by the recipient to Colorado Department of Health Care Policy and Financing (HCPF) and the Office of Behavior Health (OBH).

42 C.F.R. Part 2:

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Redisclosure:

I understand that information provided based on this Authorization may be re-disclosed to another party by the authorized recipient and that DHG has no control over the additional disclosure and cannot protect the information after it is released based on this Authorization.

Right to Revoke:

I understand that I may revoke this Authorization at any time by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions take or disclosures made while the authorization was in effect.

Conditioning:

I understand that DHG may not condition healthcare treatment, payment, enrollment or eligibility for benefits on my executing this Authorization except for research purposes, for services conducted solely to produce information for a 3rd party, or enrollment in a health plan.

Psychotherapy Notes:

The Authorization is not for a use or disclosure of psychotherapy notes as defined under HIPAA. DHG does not keep separate psychotherapy notes outside of those maintained in official record.

An Authorization may not be combined with any other document to create a compound Authorization, except for research or other authorizations.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

I understand that individuals, who are interning or training at Divine Health Group, may have access to my Protected Health Information.

This form is valid only for a one (1) year period. Each one (1) year period, DHG staff must receive written authorization to release information to complete services as planned.

This Authorization will expire one (1) year from the date of my signature

I understand that I am entitled to a copy of this authorization.

OTHER CONDITIONS:

A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Patient's Signature or Person Authorized to Sign for Patient

Person Authorized To Sign for Patient (Name & Authority)

Notice to whom this information is given:

This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the 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.