CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____ authorize: **Elizabeth Cordes Rose, DO**
PO Box 1465, Longmont CO
(405) 285-8285; (405) 285-8227 fax

The following information (please check items which apply):

☐ Demographic Information/ Diagnosis & Codes
☐ Summary of Treatment
☐ Progress Notes/Psychotherapy Notes
☐ All Records (which may contain information about substance use)
☐ Treatment Plans
☐ Psychiatric Evaluation
☐ Other: _____.
☐ Dates of Service

For the following purpose(s) of:
☐ Continued Care ☐ Insurance Billing/Claims ☐ Payment/Reimbursement for services ☐ Other_____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically from one year of date signed or on the specific event/condition: _____

Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing to the attention of: Office Manager, Elizabeth Cordes, DO, PC, PO Box 1465, Longmont, CO 80502.

Elizabeth Cordes, DO, PC is seeking this authorization and may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

_____ _____
Patient's signature Date

_____ _____
Signature of Guardian/Parent (if required) Date

_____ _____
Witness signature Date