RELEASE OF INFORMATION

This is a HIPAA compliant authorization to exchange (release and receive) confidential information concerning the individual named below for the purpose of participating in Adams County Collaborative Management Program.

Name of Individual Receiving Services (Please Print) Individual's Date of Birth

The Agencies and individuals listed below are requesting this authorization to share information about the above-named individual**. Please check the box of the agency to whom you wish to release information.**

☐	Adams County Department of Human Services	☐	Adams 12 Five Star Schools
☐	Adams County District Attorney's Office	☐	Adams 14 School District
☐	Adams County Health Department	☐	Brighton School District 27-J
☐	17th Judicial District Probation Department	☐	Strasburg School District
☐	17th Judicial District Court	☐	Bennett School District
☐	Mapleton School District	☐	Community Reach Center
☐	Westminster School District	☐	Colorado Access
☐	The Link	☐	A Precious Child
☐	Signal Behavioral Health	☐	Family Tree
☐	Colorado Youth Detention Continuum	☐	Other:
☐	Early Partnership of Adams County (ECPAC)	☐	Other:

I understand that the types of information identified in this authorization may be shared, in addition to all exceptions required or allowed by law. This authorization covers all admissions and/or contacts with the above-listed Agencies and individuals and allows a free exchange of this information between and among the Agencies and individuals I have agreed to release and receive information. I understand that the Agencies and/or individuals may need to share information among themselves more than one time and/or with other persons working for the Agencies or service providers.

The following types of Community Reach Center information may be received, used, and disclosed between the Agencies bulleted above. Please check the box of the information you wish to release.

☐	Mental Health/psychological/psychiatric history	☐	Evaluations or Treatment Progress
☐	Disabilities	☐	Treatment Plans
☐	Diagnoses	☐	Other:

The following types of information may be received, used, and disclosed between the Agencies bulleted above. Please check the box of the information you would like to release to the above agencies:

☐	Demographic information that identifies me, my child or ward	☐	Work, school and social reviews, status, and histories
☐	Agencies records (non-Community Reach Center) which have information about medical or mental health/psychological/psychiatric history, disabilities, diagnoses, evaluations or treatment	☐	Plans about services or benefits
☐	Sex offender evaluation and treatment information	☐	Eligibility and insurance coverage information
☐	Information on finances	☐	Placement history
☐	Referral sources	☐	Adjudication status
☐	Probation file, including the presentence investigation report and its attachments, if applicable. Note that Probation **shall not** release the NCIC/CCIC report, victim location information, copyrighted instruments or	☐	Information relating to my/our prior or current involvement with child protection, adult protection, prevention, case management, financial assistance, and

☐	documents the author has indicated in writing should not be released. Legal history	☐	housing services, the content of those interactions, including issues and concerns relating to my/our treatment plans and other interventions
☐	Other:	☐	Other:

The purpose of any disclosure within the Agencies and/or with the individuals will be that the Agencies and/or individuals above will release and receive confidential information only when they need the information to manage, provide, or make service recommendation for me, my child or other person for whom I am legally responsible (ward).

This authorization remains valid unless one of the below applies, *whichever is sooner:*

- the authorization expires two years from the date I sign the form; or
- when I revoke this authorization by submitting a signed and dated attestation to Adams County Collaborative Management Program Coordinator, c/o Adams County Children & Family Services, 11860 Pecos St. Westminster, CO 80234; or accmp@adcogov.org

I, _____, hereby revoke any previous authorizations to disclose my protected health information. I understand that this revocation prevents further disclosures or actions and cannot cancel prior actions or disclosures made while this release of information was in effect. Print Name:_____ Date: _____

Signature: _____ Phone:_____ Email: _____

I understand that the information covered by this authorization may be disclosed for data sharing and data collection purposes within the Agencies and may also be used for other legal purposes.

Authorizations related to Alcohol and Drug Use and Treatment:

I understand that my alcohol and/or drug treatment records are protected by federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and may also be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164, and cannot be disclosed without my written consent (as given by signature on this form) unless otherwise provided for in the regulations.

☐	**YES**, I authorize the above agencies to release information regarding substance use and treatment.
☐	**No, I do not** authorize the above agencies to release information regarding substance use and treatment.

I understand that this is a HIPAA-compliant Authorization and as such, the Agencies and/or individuals may not condition treatment, payment, enrollment or eligibility for benefits on my signing this Authorization. I understand that I can still apply for and receive services on my own, my child's, or my ward's behalf without signing this form.

I understand I will be given a copy of this form. A person may use a copy or facsimile (FAX) of this form in place of the original signed authorization form. By signing this Authorization form, I agree that I have read and understand the information on this form. I understand that there is the potential for re-disclosure by the recipient and that it may no longer be protected by the HIPAA Privacy Regulation.

Specific health information will not be shared, unless I select this information below:

☐	**YES**, I authorize the above agencies to release HIV/AIDS related information and/or records

_____ _____ _____

Signature of Individual Receiving Services or Parent/Legal Guardian*

Print Name

Date

_____ _____ _____

Signature of Parent/Legal Guardian

Print Name

Date

_____ _____

Signature of the youth if over the age of 15 and requesting mental health records, or if over the age of 18 for all other records

Date