Authorization to Disclose Protected Health Information (PHI) Form

The purpose of this form is to request the authorized disclosure of PHI in accordance with the Health Insurance Portability and Accountability Act (HIPAA).[1] A client or an authorized individual identified by the client as involved in the client's care may complete this form.[2] This form must be legible to be valid.

Client name: _____ **Client date of birth:** _____

Client contact information (e.g., telephone, address, email):

I authorize the disclosure of my PHI between the following parties (please check "From" and "To"):

☐ **From or** ☐ **To:**
Colorado Coalition for the Homeless (CCH)
Attn: Medical Records
2130 Stout Street, Denver CO 80205
Phone Number: (303) 312-9799
Fax Number: (303) 296-8826
Email: records@coloradocoalition.org

☐ **From or** ☐ **To:**
Name or Entity: _____
Relationship to client: _____
Address: _____
Phone Number: _____
Fax Number: _____
Email: _____

Date of treatment range (month/year) **From:** _____ **To:** _____

☐ **Only verbal disclosure of PHI (i.e., communication with the party identified on this form)**

PHI requested to be disclosed (please check all that apply):

- ☐ Medical records without special categories of PHI
- ☐ Visit summary
- ☐ Pharmacy records
- ☐ Dental records
- ☐ Optical records
- ☐ Laboratory results
- ☐ Radiology Reports / Imaging

Special categories of PHI:

- ☐ Sexually transmitted diseases
- ☐ HIV and AIDS
- ☐ Behavioral or mental health without psychotherapy notes[3]
- ☐ Substance Use Disorder (SUD) without counseling notes[4]

Other PHI not specified above (please print clearly):

Purpose of the disclosure (please check all that apply):

- ☐ Continuity of care (i.e., treatment)
- ☐ Obtain and qualify for benefits
- ☐ Third-party review

Other purpose of the disclosure (please print clearly):

Acknowledgement (please review prior to signing this form):
I understand that PHI disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that CCH has acted in reliance upon it. My authorization will expire two (2) years from the signature date, or upon termination of services with CCH, whichever comes first.

Signature of client or authorized individual: **Date of signature:**

_____ _____

Authorization Statements

By signing this Authorization to Disclose Protected Health Information (PHI) Form I understand the following:

- I am voluntarily signing this authorization form.
- I do not need to sign the authorization form to ensure that I receive health care treatment from CCH.
- I understand that I may refuse to sign this authorization. If I refuse to sign this authorization my health care benefits or payment for my health care benefits will not be affected.
- I understand that if I request to receive PHI via unsecured email, unencrypted messages including attachments can be read, and potentially copied and forwarded, by anyone, and its confidentiality may no longer be protected by federal or state law.
- Multiple requests to disclose PHI may be authorized if the purpose for the disclosure remains the same.
- Due to the integrated health care provided by CCH, I understand that my PHI disclosed may include a diagnosis or reference to the following condition(s): behavioral health and/or psychiatric care; Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), or and/or Substance Use Disorders (SUD) but that information will not be explicitly disclosed unless specified by selecting the box marked special categories of PHI.
- Individuals enrolled in CCH licensed substance treatment programs have their substance use-specific PHI protected by 42 CFR Part 2.
- I have the right to revoke this authorization, in writing, at any time, except to the extent that CCH has acted in reliance upon it. I understand that I may contact CCH in writing to revoke and cancel this authorization at:

  Colorado Coalition for the Homeless (CCH)
  Attn: Medical Records
  2130 Stout Street, Denver CO 80205
  Phone Number: (303) 312-9799
  Fax Number: (303) 296-8826
  Email: records@coloradocoalition.org

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from information protected by federal confidentiality rules (HIPAA and 42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information that identifies a client as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of PHI or other sensitive information is NOT sufficient for this purpose (see § 2.31). 42 CFR part 2 prohibits unauthorized use or disclosure of these records.

[1] 45 CFR 164.506 Uses and disclosures to carry out treatment, payment, or health care operations. HIPAA permits Covered Entities to use and disclose PHI without the client's verbal or written authorization for the purposes of treatment, payment, or health care operations.
[2] 45 CFR 164.502(g) Uses and disclosures of protected health information: Personal Representatives. A Covered Entity must treat a Personal Representative the same as the individual (i.e., client).
[3] 45 CFR §164.508 Uses and disclosures for which an authorization is required. HIPAA requires the client's written authorization to use and disclose special categories of PHI such as psychotherapy notes even for treatment, payment, or health care operations purposes. HIPAA defines psychotherapy notes as notes recorded by a healthcare provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record.
[4] Substance use disorder (SUD) records from licensed treatment programs are protected under 42 CFR Part 2. SUD counseling notes require separate consent and should not be released under this form.