



### Release of Information

Client / Defendant Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**To provide information TO/FROM:**

Person/Provider: CCAO/GRACe Program.

Address: 150 Quality Hill, Bisbee, AZ 85603

Phone Number: 520-432-8738

**This authorizes:**

Person/Provider: Cochise County Attorney's Office.

Address: 150 Quality Hill, Bisbee, AZ 85603

Phone Number: 520-432-8700

**General Permissions:**  Medical  Dental

- |  |   |
|--|---|
| <input type="checkbox"/> 3 months of the most recent records             | <input type="checkbox"/> All records (only 2 years, unless other dates are specified) |
| <input type="checkbox"/> Lab Dates (from) _____ (to) _____               | <input type="checkbox"/> X-rays: Dates (from): _____ (to): _____                      |
| <input checked="" type="checkbox"/> Other: Diagnosis /SMI /Determination |   |

*No more than 50 pages via fax. If more than 50 pages, please mail.*

**Special Permissions:**

**Mental/Behavioral Health Services**

- All mental/behavioral health/psychotherapy records
- Only psychotherapy records
- I want to review these records before they are released. I understand my review will be supervised in the Health Information Management Department.
- Do not release this information

**Drug/Alcohol/Medication Assisted Therapy**

- Include all Drug/Alcohol/MAT records
- Include only the specific information:
  - Clinical Notes and Discharge Summaries (including therapy notes)
  - Lab & Other Diagnostic Test Results
  - Assessment/Screening Results
- Do not release this information

**HIV/AIDS Information**

- Include this information in the release
- Do not release this information

**Purpose for need of disclosure:**

- At the request of the individual to transfer care
- At the request of the individual to coordinate care

I understand that my medical records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Information Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations.

I understand that **I have a right to revoke this authorization** at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocations will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: \_\_\_/\_\_\_/\_\_\_, or if I fail to specify an expiration date, **this authorization will expire in one (1) year.**

I understand that authorizing the disclosure of this health information is voluntary. **I can refuse to sign this authorization.** I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed, as provided in **CFR 164.524.** I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

\_\_\_\_\_  
Signature of Client/Defendant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Relationship to Client/Defendant