Authorization for Release of Information

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Patient's Name Birth Date Phone

I understand that my records are protected by Comprehensive Human Services' confidentiality policies as mandated by C.R.S. 7.714.211. In addition, I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **1 year from the date indicated below.** Signing this form is voluntary and the signor has a right to receive a copy.
I further understand that by signing below, I am authorizing the release or exchange of these records to The parties named below. I understand that I may revoke this authorization at any time by notification in writing. Ihereby authorize (check all that apply):
__ Exchange with __Release to __Obtain from the parties I have indicated below
Person/organization receiving/communicating the information:
Name:
Address:
Phone Number Fax
Nature of information)to be released/exchanged/obtained:

Anything that is beneficial in my treatment plan

Signature of Patient/Legal Guardian _____Date_____

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Name of Patient Relationship to Patient