ASPEN
mental health

Authorization For Release of Information

I (We) authorize Aspen Mental Health to release, disclose, receive or exchange information from the clinical record of:

_____

Name of client/recipient of mental health services Date of birth

To or from the following persons/entities and allow such information to be inspected and copied by:

PCP/Person/Entity: _____

Address/Location of PCP/Person/Entity:_____

Information to be disclosed: _____

Information to be disclosed (ex: all treatment records)

For the purposes of _____

State purpose for disclosure (ex: continuity of care)

Substance Use/Infectious Disease Disclosure:
By selecting "yes" to the following, you are consenting to the release and exchange of information that may include any available ***substance use/abuse or HIV/Infectious disease*** information. Please select "no" if you do not wish for this information to be disclosed**.** ☐ **Yes** ☐ **No**

- By providing your initials, you are indicating that you have understood the above statement and have made your desired selection: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to the office of Aspen Mental Health. I understand that a revocation is not valid to the extent that Aspen Mental Health has acted in reliance on such authorization. **This authorization is valid for one year from the date of signature or until the date specified. Validation of release shall not exceed one year.**

Specified end date: _____ *(Date)*.

A copy of this release shall have the same force and effect as the original. By signing below, I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

_____

Client Signature (12 yrs. or older) **Date**

_____

Parent/Guardian Signature **Date**

_____

Staff Signature **Date**

NOTICE TO RECEIVING FACILITY/COUNSELOR: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.