



### Authorization for Release of Offender Medical, Mental Health or Substance Abuse Treatment Information

Correctional Healthcare Companies will not condition treatment on this authorization. Mental health information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization from the offender or offender's representative. If this authorization is for psychotherapy notes, it must not be used as an authorization for any other type of protected health information. If authorizing disclosure to persons or organizations that are not health plans, covered health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information. However, genetic testing or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization.

I hereby authorize the **Larimer County Jail** to release:

**Section A: Medical and Mental Health Information (as described below):**

\_\_\_\_\_ State specific Health information to be disclosed including date(s) or date range  
\_\_\_\_\_  
\_\_\_\_\_

**Section B: Substance Abuse Treatment Information (as indicated below):**

If Substance Abuse Treatment records are being authorized, initial all relevant areas below:

_____ Diagnosis	_____ Toxicological Reports/Drug Screens	_____ Educational Information
_____ Evaluation/Assessment	_____ Medication Management Information	_____ Attendance in Treatment
_____ Treatment Plan	_____ Summary of Treatment Services	_____ Treatment Progress Report
_____ Continuing Care Plan	_____ Other (specify): _____	

Include date(s) or date range: \_\_\_\_\_

At Request of Offender and/or: \_\_\_\_\_ Purpose of disclosure \_\_\_\_\_

From the records of \_\_\_\_\_ ID# / DOB \_\_\_\_\_ Print Offender's Name \_\_\_\_\_

to:  Self  Authorized Attorney  Health Care Facility  Other: \_\_\_\_\_

Name: \_\_\_\_\_ Print Name \_\_\_\_\_

Address: \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I hereby release and hold harmless Correctional Healthcare Companies and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. Records disclosed may contain confidential medical information including HIV disease information. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the Facility Privacy Officer.

**Expiration:** This authorization will expire (complete one):

45 days from date of signature  
 Upon the occurrence of the following event (must relate to the individual or purpose of the authorization): \_\_\_\_\_  
\_\_\_\_\_

**Signature:**

\_\_\_\_\_  
Signature of Offender or Person Authorized to Consent Relationship Date

**Witness:**

\_\_\_\_\_  
Print Name Title  
\_\_\_\_\_  
Signature Date

(File the signed authorization in the Offender's Medical File)  
(Give Offender a copy if the RHA made the request for release)