Case Management

CONSENT TO DISCLOSE
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT INFORMATION

This **Consent to Disclose** is needed for the provision, coordination, and management of the health care received by:

Client's Name (Print)	Date of Birth	MRN
_____	_____	_____

I consent to the disclosure of my health information (described below) among the representatives of the following agencies, for the provision, coordination, and management of my health care:

- Bridges of Colorado
- Catholic Charities
- Colorado Legal Services
- Disabled Resource Services
- Division of Vocational Rehab
- Foothills Gateway
- Foundations Church,
- Housing Catalyst
- Health District of Northern Larimer County
- Homeward Alliance (Murphy Center)
- The Jacob Center
- Larimer County DHS Benefits Department
- Larimer County Economic and Workforce Development Center
- Loveland housing authority
- Matthews House
- Neighbor to Neighbor
- Rocky Mountain Human Services
- Salvation Army
- Serve 6.8
- Sober Living: Oxford House, Abundance Foundation, Light House, Purpose House Sober Living
- Social Security Administration
- United Way

Health Information Disclosed: The agencies listed above have my permission to communicate with each other verbally only for **the purpose of coordinating care with community support resources**. Treatment information will not be shared without my separate written consent. The information shared will solely be used to develop a treatment plan, assess the plan's effectiveness, and to coordinate care.

Time Frame: This consent is subject to revocation by the client at any time, except to the extent that the agencies noted above have already acted in reliance upon it. If not previously revoked, this consent will expire on _____ but not more than two (2) years from the date of signature.

I have read, understand, and agree to the above information:

Client (Print)	Signature	Date
_____	_____	_____

Print Parent / Legal Representative (If Required)	Signature Relationship to Client _____	Date
_____	_____	_____

Notice of Disclosure: I understand that my records, or those of anyone I listed, are protected by federal and state privacy laws. If I allow the release of substance use disorder information, it is protected by federal law (HIPAA and 42 CFR Part 2). This means it can't be shared again without my written consent, unless the rules say it's okay. I know I can take back my consent at any time, except if SummitStone has already acted on it. I agree that this release form can be sent to the people and agencies listed above. For health information not about substance use, if I allow it to be shared, the person who gets it may share it again, and federal privacy laws might not protect it anymore. For substance use disorder information, if I allow it to be shared, the person who gets it may share it again, but federal privacy laws will still apply.

AUTHORIZATION TO REVOKE RELEASE

*By signing below, I am **REVOKING** permission for SummitStone to release any of the information previously permitted to be released.*

Signature of Client, Parent/Guardian (for client under 15, if applicable), or Authorized Representative	Date of Signature
_____	_____