MIND SPRINGS *health* WEST SPRINGS *hospital*
Prevention. Care. Recovery. Psychiatric Care & Recovery

Client Release of Information / Authorization for Use and Disclosure

Client First & Last Name: _____ Client Date of Birth: _____

Today's Date: _____ Status: ___Active ___Revoke ___Void ___Client Declined

QHN Authorization:
I authorize Mind Springs Health/West Springs Hospital to disclose my treatment information, including all substance use disorder information, to Quality Health Network (QHN) where it can be accessed by all (past, present, & future) QHN participants who have a treating provider relationship with me. QHN is a health information exchange that moves clinical information among healthcare providers and systems with the purpose to provide coordinated, timely, and patient-centered care. I understand that I am entitled, upon request, to a list of all QHN participants to who my information was disclosed.
Client approved the above consent to QHN: _____Yes

As a Mind Springs Health or West Springs Hospital client, I understand that state and federal regulations govern the confidentiality and protection of my individually identifiable health information (CFR 42 Part 2, CRS 25.1, HIPAA). Except in situations legally required or permitted, information about me cannot be disclosed to persons or agencies outside Mind Springs, Inc. without my written permission. I understand that additional protections exist for substance abuse information and for HIV/AIDS information.

I hereby authorize Mind Springs, Inc. to send, receive, exchange, use or disclose health information about me to:
One (1) form per authorization is required.

Third Party Relationship to Client: _____
Contact Name: _____ Phone Number: _____
Agency: _____ Fax Number: _____
Address: _____ City, State: _____

I consent to release the following types of information listed: (Please mark all that apply)

___All Substance Use Information
___HIV/AIDs Information
___Medical/Lab Information
___Payment/Balance Related Information
___Psychological/Neurological Testing
___Update and/or Discharge Summaries
___Diagnostic Assessment
___Legal Information
___Medication Management/Progress Notes
___Psychiatric Evaluations
___Social History/Background
___Other (please specify)
_____

Purpose: (Please select at least one)

___Continuity of Care
___Coordination of Services
___Treatment
___At the Request of the Individual
___Other (please specify)
_____

Mind Springs Health & West Springs Hospital
Medical Records Department
515 28 3/4 Road
Grand Junction, CO 81501

Phone: (970) 683-7252
Fax: (970) 683-7055

HOSPITAL USE ONLY!
Allowed Visitations: ☐ Yes ☐ No Telephone Calls Allowed: ☐ Yes ☐ No

Re-disclosure
I understand that information disclosed based on this Authorization, except for information about a substance use disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

Prohibition on Conditioning of Authorizations
I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. Mind Springs Health/West Springs Hospital may not refuse to treat me if I refuse to sign this Authorization, unless this Authorization is necessary for my participation in a research study or the purpose of the treatment is to provide information to the individual/entity identified in this Authorization.

Expiration and Right to Revoke (Cancel)
I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire in two (2) years from the date I sign it unless an earlier date is specified here:

Expiration Date: _____

_____ _____
Client or Representative Signature If Representative, Relationship to Client

Witness Name: _____