MINES & ASSOCIATES
A National Business Psychology Firm

www.MINESandAssociates.com

Employee Assistance & Wellness Programs
Specialty Behavioral Health Network
Managed Behavioral Healthcare
Organizational Development

Corporate Address: 10367 West Centennial Road | Littleton CO 80127
Toll-Free: 800-873-7138 | Local: 303-832-1068 | Fax: 303-832-9701

Authorization for Release of Health Information

I, _____ hereby authorize MINES & Associates (MINES) or its agent(s) to disclose my health information as described in this authorization.

[1] Specific person(s)/organization(s) to whom MINES is authorized to disclose the information:

_____

_____

_____

_____

[2] Specific description of the information to be disclosed by MINES:

_____

_____

_____

_____

[3] ***Right to Revoke***: I understand that I have the right to revoke this authorization at any time by notifying MINES in writing at 10367 W. Centennial Rd., Littleton, CO 80127. I understand the revocation is only effective after it is received by MINES. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

[4] ***Potential for Redisclosure***: I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it.

[5] ***Right to Copy***: I understand that I am entitled to receive a copy of this authorization.

[6] ***Expiration of Authorization***: This authorization will expire [*choose and complete one*]:

___ On the _____ day of _____, 20___.

___ Upon the occurrence of the following event: _____

[7] ***Voluntary***: I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party or parties I have designated.

[8] ***Purpose of Authorization***: I am requesting that my Protected Health Information be disclosed for the following purpose:

[9] ***Photocopy or Facsimile***: A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had the opportunity to review and understand the contents of this form. By signifying this form, I am confirming that it accurately reflects my wishes.

_____ _____

Date Individual Signature

Complete the following only if you are a Personal Representative signing the form on behalf of the individual.

If a Personal Representative executes this form on behalf of the individual, the Personal Representative warrants that he or she has authority to sign this form on the basis of:

____ A power of attorney for health care purposes including the right to access protected health information (copy attached).

____ A court order of appointment as the conservator or guardian of the individual (copy attached).

____ An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law exceptions).

____ Other: _____.

NOTICE TO RECEIVING AGENCY/PERSON:

This information is confidential and you may not disclose any information unless the person consents. You are bound by Federal and Colorado law regarding confidentiality of Alcohol and Drug Abuse patient records; neither such records nor information from such records may be further disclosed without specific authorization.