State of Colorado

Authorization — Consent to Release Information

This is a(n) Choose One: | Date of Prior Request (if applicable):

Agency Requesting Information:

Name of Agency		Name of Agency Representative	
Address of Agency			
City	State Choose One	Zip	Email
Phone 1	Phone 2	Fax	Date

Youth Information

Full Name Last Name	First Name	MI	Date of Birth	
Mailing Address				
City	State Choose One	Zip	Phone	
Type of Identifier: ☐ SSN ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD#			Identifier:	

Name of Consenter/Person Authorizing Consent

Name			
Mailing Address			
City		State Choose One	Zip
Email	Phone 1	Phone 2	
Type of Identifier: (Choose One)	Identifiers:	Role: (Choose One)	

Authorizes:

☐ CDE	☐ District Court	☐ Municipal Probation	☐ Attorney/PD	☐ GAL
☐ CDCW	☐ LEA	☐ District Probation	☐ JAC	☐ DYC
☐ OBH	☐ District School	☐ Diversion	☐ SB94	☐ County Court
☐ Municipal Court	☐ Private School	☐ DA	☐ County DHS	
☐ Service Provider		☐ Other		

To Release Information To:

☐ CDE	☐ District Court	☐ Municipal Probation	☐ Attorney/PD	☐ GAL
☐ CDCW	☐ LEA	☐ District Probation	☐ JAC	☐ DYC
☐ OBH	☐ District School	☐ Diversion	☐ SB94	☐ County Court
☐ Municipal Court	☐ Private School	☐ DA	☐ County DHS	
☐ Service Provider		☐ Other		

To Receive Information From:

☐ CDE	☐ District Court	☐ Municipal Probation	☐ Attorney/PD	☐ GAL
☐ CDCW	☐ LEA	☐ District Probation	☐ JAC	☐ DYC
☐ OBH	☐ District School	☐ Diversion	☐ SB94	☐ County Court
☐ Municipal Court	☐ Private School	☐ DA	☐ County DHS	
☐ Service Provider		☐ Other		

For the Purpose of: (Choose One)

Type of Records/Information Requested:

Education	Substance Abuse	Medical	Mental Health	Court	Other Records
☐ School Grades	☐ Treatment History	☐ Current Prescription	☐ MH Intake	☐ Probation History	☐ Human Service Records
☐ School Attendance Records	☐ Treatment Screens	☐ Medical History	☐ MH Screen	☐ Programs	☐ Child Welfare History
☐ School Behavior Reports	☐ Evaluations	☐ Immunizations	☐ MH Treatment History	☐ Pre-Trial Services	☐ Other:
☐ IEP's/504		☐ HIV/AIDS	☐ Diagnosis	☐ Other Court Records	Please Specify

Date Range of Youth Records: **From:** **To:**

Date Range of Authorization/Consent: **From:** **To:**

How is this infomation being released? ☐ Fax ☐ Email ☐ Telephone ☐ In Person ☐ Other Please Specify

Signature of person authorizing consent: Date:

Type or print name:

Signature of youth: Date:

Type or print name:

☐ By my signature, I consent to the release of information contained on this form for use by the requesting agency(cies) , and I understand that any agency or individual using the confidential information or records obtained will take all necessary steps to protect the confidentiality of the above named youth's identity. I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form.

☐ Consenter declined release of information. _____[staff initial]
[Copy Provided to Client]

Confidentiality Notice for Electronic Transmittal:
This release, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. If you have received this communication in error, please immediately notify the sender. In addition, if you have received this in error, do not review, distribute, or copy the document or attachments.

Consent Expiration:
This authorization - consent expires on/no later than DATE, or at end of event, completion of treatment, whichever is less. Length of time consent is valid can be specific by program or provider, or set by length of program/ referral, period of time that records are utilized for specified consent purpose. See specific agency authorization and consent rules for agency specific time frames for record retention.

Authorization/Consent Period:
This release shall remain in effect until such time as I provide the (AGENCY) with a written or oral notification to revoke. Exceptions do not cover data that was previously released for specific treatment or referral.

Copies of Authorization/Consent Valid:
A copy, photocopy, or facsimile transmission of this release will have the same authority as the original. ***Colorado Office of Information Technology Policy Colorado Open Records Act (sections 24-72-201, et. seq.), the laws governing state archives and public records management (sections 24-80-101, et. seq.) or local statute. Governmental entities that agree to conduct a transaction by electronic means may refuse to conduct other transactions by electronic means (see Section 24-71.3-105).***

Interdepartmental data protocol:
In Interdepartmental data protocol means an interoperable, cross-departmental data management system and file sharing procedure that permits the merging of unit records for the purposes of policy analysis and determination of program effectiveness. The Interdepartmental data protocol at a minimum shall include protocols and procedures to be used by state agencies in data processing, including but not limited to collecting, storing, manipulating, sharing, retrieving, and releasing data related to the named juvenile. See Colorado Juvenile Risk Assessment (CJRA) C.R.S.§ 19-2-922 and Attorney General Model Acts for data exchange- C.R.S. § 19-1-304(2)(a)(XV)

Non-consensual Release of Confidential Treatment Data:
Under the State of Colorado and Federal Confidentiality Regulations, no information about the juvenile's participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order.

Disclosure Notice to Receiving Agencies:
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL LAW PROHIBITS YOU FROM MAKING FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. IF APPLICABLE, A MINIMUM NECESSARY DETERMINATION HAS BEEN APPLIED TO THIS RELEASE/ AUTHORIZATION. IF YOU HAVE QUESTIONS CONCERNING THIS RELEASE PLEASE CALL (PROVIDER AGENCY PHONE #) OR PLEASE SEND INFORMATION TO: (PROVIDER AGENCY NAME AND ADDRESS AND FAX)

Revocation Limitation:
This release/authorization may be revoked at any time by written notice to AGENCY, except to the extent that action has already been taken to comply with it. Without such revocation, this release/ authorization will expire on (specific date) or if left blank, one year from the date signed, or if included as part of a Court Order or condition of probation, upon the terms specified. Consenter may revoke consent in writing by contacting the releasing agency. This revocation will be recorded in the AGENCY record. HIPAA requires written revocation of an authorization to release HIPAA information (45 CFR §164.508(b)(5)). Both Part 2 and HIPAA allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a)(8) and 45 CFR §164.508.

Treatment Data Disclosure Limitation:
Under the State of Colorado and Federal Confidentiality Regulations, no information about NAMED child's participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order. A substance abuse treatment program is defined as an individual or entity that provides alcohol or drug abuse diagnosis, treatment or referral. In this document, the term "program" includes both individual substance abuse providers and substance abuse provider organizations. See also Colorado Mental Health Treatment records http://www.leg.state.co.us (SRS Art 25(Health, Title 1 Administration, Part 8 and Colorado Medical Records Access Laws http://www.leg.state.co.us/

Written/ Verbal Authorization/ Consent:
This consent must be in writing to be valid, unless consent is for Substance Abuse Treatment – when verbal consent is acceptable. Verbal consent may also be accepted in specific emergency situations. See agency specific policies for more details.

Electronic Transmission of Personal Information:
It is a violation of law to electronically transmit any form which contains "Personal information" (a Colorado resident's first name or first initial and last name in combination with any one or more of the following data elements that relate to the resident - Social Security Number (SSN); Driver's license number or identification card number; Account number or credit or debit card number, in combination with any required security code, access code, or password that would permit access to a resident's financial account) when the data elements are not encrypted, redacted, or secured by any other method rendering the name or the element unreadable or unusable. See C.R.S.6-1-716, 1(a)

Preparer's Intitials _____ **Consenter's Intitials** _____

Preparer's Intitials		Consenter's Intitials	

Preparer's Intitials

Consenter's Intitials

Clear Form

Email Form

Print Form