Interagency Treatment Group

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:

___________________________________ __________________________
Patient's Name (Print) Date of Birth

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

Adult Protection Services, Banner Health ER, Colorado State University (Case Management, Police Services), Catholic Charities, Denver Rescue Mission, DOC Parole, 8th Judicial District Probation Department, Family Medicine Center, Foothills Gateway, City of Fort Collins specifically: Housing Catalyst, Outreach Fort Collins, Fort Collins Police Services, Municipal Court Special Agency Session), Health District of Northern Larimer County, Larimer County specifically: (District Attorney's and Sheriff's Offices, Jail and its counseling programs, Community Corrections, AIIM Program, Wellness Court, Department of Human Services), Loveland Police, Murphy Center, North Range Behavioral Health Detox Center, Poudre Fire Authority, Salud Clinic, SummitStone Health Partners, University of Colorado Health North (Emergency Department, Crisis Assessment Center, Ambulance Service, Medicaid Accountable Care Collaborative, MountainCrest, Mobile Assessment Team, Medical Center of the Rockies), Veterans Administration Multispecialty Outpatient Clinic.
Additional Agency (Print): __________________________________

Health Information Disclosed: Members of the Interagency Treatment Group have my permission to disclose, among themselves, my mental health and substance abuse treatment information in oral format only. Written treatment records may 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 at any time, except to the extent that the members of the Interagency Treatment Group have already taken action in reliance upon it. If not previously revoked, this consent will expire on (list specific date, event, or condition): _______________________.

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

____ __________
Patient Name (Print) Signature Date

____ __________
Name (Print) Signature Date
Parent / Legal Representative (If Required) Relationship to Patient ________________

Notice to Recipient of Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.