ASPENPOINTE INTERAGENCY RELEASE OF INFORMATION OR AUTHORIZATION

(Participant's Name – First, Middle Initial, Last) **(Date of Birth)** **(Social Security Number)**

I authorize information about the above referenced participant to be exchanged between the following System of Care User Group agencies or programs as listed below (check all that apply) to carry out activities related to the services the Participant receives from AspenPointe such as claims/encounters, care coordination, utilization management, quality assurance, handling appeals/grievances, and other administrative activities related to treatment, payment, and operations.

Note – AspenPointe Health Services clients are part of the Pikes Peak Community Health Partnership (PPCHP), a Colorado Regional Care Collaborative (RCC), through which you can receive healthcare services as needed. PPCHP utilizes client data for 2 purposes:

1. Individual client care coordination among providers in order to better assess client overall needs and design treatment plans that serve the whole-person needs of clients common to both organizations.
2. Population health management through analysis of healthcare data with the goal to improve healthcare outcomes for identified populations with efficiencies of operations and cost savings.

This release is necessary to effectively share your information with PPCHP to insure you receive the best, most collaborative care.

- ☒ ASPENPOINTE
- ☐ CASA – Court Appointed Special Advocate
- ☐ Child Care Connections
- ☐ Child Care Response Team
- ☐ Colorado Child Care Assistance Program (CCCAP)
- ☐ Community Partnership for Child Development
- ☐ Court: _____
- ☐ Dept. of Human Services Program(s): _____
- ☐ Educational Program/School District:
- ☐ EPC Dept. of Health & Environment Program(s)
- ☐ Faith Partners: _____
- ☐ Financial: _____
- ☐ GAL – Guardian ad Litem
- ☐ Health Care: _____
- ☐ Healthcare for Children with Special Needs (HCP)
- ☐ Hospital: _____
- ☒ Medicaid Clients only- Colorado Department of Health Care Policy and Finance (Medicaid), Colorado Health Partnerships, Access Behavioral Health, Behavioral Healthcare, Inc, Foothills Behavioral Health Partners, LLC
- ☐ Military Program: _____
- ☐ Pikes Peak Family Connections
- ☒ Pikes Peak Community Health Partnerships
- ☐ Private Behavioral Health Therapist: _____
- ☐ Resources for Young Children & Families (Part C)
- ☐ Social Security Service
- ☐ TESSA (Domestic Violence Prevention)
- ☐ The Resource Exchange (TRE)
- ☒ Value Care Health Clinic
- ☒ Beacon Health Options – Medicaid clients only
- ☐ WIC – Women Infants and Children
- ☒ PCP: _____
- ☐ Other: _____
- ☐ Other: _____

I agree that information to be released/authorized may include the following condition(s): Check all you agree to release:

☒ Drug Abuse ☒ Alcoholism or Alcohol Abuse ☒ Psychiatric Conditions/Treatment ☒ HIV/Auto Immune Deficiency Syndrome (AIDS)

Generally confidentiality laws prohibit a covered entity like AspenPointe from using or disclosing PHI unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality healthcare or with certain other important public benefits or national priorities. Ready access to treatment and efficient payment for healthcare, both of which require use and disclosure of protected health information, are essential to the effective operation of the healthcare system. In addition, certain healthcare operations – such as administrative, financial, legal, and quality improvement activities – conducted by or for healthcare providers and health plans, are essential to support treatment and payment. To avoid interfering with an individual's access to quality healthcare or the efficient payment for such healthcare, the HIPAA Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and healthcare operations activities.

I understand that information provided based on this Authorization may be redisclosed to another party by the authorized recipient, and that AspenPointe has no control over the additional disclosure and cannot protect the information after it is released based on this Authorization.

I understand that I may revoke this Authorization at any time in writing to the address below. I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions take or disclosures made while the authorization was in effect.

I understand that AspenPointe may not condition my healthcare treatment or payment, or my enrollment or eligibility for benefits on my executing this Authorization except for research purposes, for services conducted solely to produce information for a 3rd party, or enrollment in a health plan.

The Authorization is not for a use or disclosure of psychotherapy notes as defined under HIPAA. AspenPointe does not keep separate psychotherapy notes outside of those maintained in the official record.

An Authorization may not be combined with any other document to create a compound Authorization, except for research or other authorizations.

I certify that this authorization has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

I understand that I may revoke this authorization, at any time, by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. Without such revocation this authorization will expire on / / , or if left blank, 2 years from my signature date, or as of the action/event of

☐ I understand that I am entitled to a copy of this authorization.

Signature of Participant/Authorized Guardian/Legal Representative	**Authority to act on Participant's behalf**	**Date**

☐ I hereby revoke this Authorization to Disclose Information.

Signature of Participant/Authorized Guardian/Legal Representative	Authority to act on Participant's behalf	Date

Notice to whom this information is given: This information has been disclosed to you from records that may be 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.

A copy/facsimile of this authorization is as valid as the original ☐ Original ☐ Revised (Date ___/___/___)