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

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
515 28 3/4 Road
Grand Junction, CO 81501

Medical Records Department
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 Date **If Representative, Relationship to Client**

Witness Name: _____

Revised: 3/2024