

Elbert County Coalition for Outreach

Informed Consent Form Authorizing Release of Confidential Information

I, _____ hereby authorize
Name of Client DOB

Elbert County Coalition for Outreach P.O. Box 1906, Elizabeth, CO 80107 (303) 621-2599

To disclose to/receive from the following:		Check Appropriate Boxes	Initials
AGENCY/ADDRESS	CONTACT PERSON/PHONE		
		<input type="checkbox"/> Release <input type="checkbox"/> Request	
		<input type="checkbox"/> Release <input type="checkbox"/> Request	
		<input type="checkbox"/> Release <input type="checkbox"/> Request	
		<input type="checkbox"/> Release <input type="checkbox"/> Request	
		<input type="checkbox"/> Release <input type="checkbox"/> Request	
		<input type="checkbox"/> Release <input type="checkbox"/> Request	
		<input type="checkbox"/> Release <input type="checkbox"/> Request	

For the Purpose of: Coordination of assistance and services provided to me.

I understand that Elbert County Coalition for Outreach (ECCO) has a variety of member agencies that work together to provide services. No individually identifying information about me will be shared with ECCO member agencies or other agencies or persons without my consent. Only information needed for the provision of services I have requested will be shared with agencies and individuals I have designated.

This Consent to Release includes any health information or medical records which may be part of the above-stated records, including any alcohol or drug treatment records, which are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Pts. 160 & 164. I understand that none of the treatment providers listed herein may condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization. Information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand and agree that this release form may be sent to the agencies and persons identified above. Copies of this form may be used in place of the original signed form.

I understand that there is potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by HIPAA Privacy regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based upon it. This consent expires and cannot be used past the indicated date or event.

Expiration Date: _____ OR Expiration Event: _____
 (Not more than one year)

This Consent to Release has been explained to me. I have read it (or it was read to me) and I understand its provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit the sharing of this information. I hereby willingly agree to the sharing of information as described above. I am signing this document of my own free will, no one has threatened or coerced me into signing this document I have received a copy of this document.

 X
 CLIENT SIGNATURE Date

 X
 ECCO Staff Signature Date

I hereby revoke this Consent to Release	
Client Signature	Date

A COPY OF THIS RELEASE SHOULD BE PROVIDED TO THE CLIENT