CONSENT TO RELEASE FORM

AUTHORIZING RELEASE OF CONFIDENTIAL INFORMATION

I, _____, on behalf of myself and/or my children and/or wards (listed below), authorize the sharing of information between the agencies and individuals listed on page two (2); my execution of this Consent to Release releases these agencies and individuals from any and all liability arising from the release and disclosure of such information and records.

Print Name of Each Child and/or Ward	Date of Birth

I authorize(s) the following confidential information to be released and disclosed between the agencies listed on page two (2): (check the item descriptions that apply)

- ☐ Child Welfare Information, e.g., social worker case file; medical; psychological and education consultation reports; court reports; relinquishment and adoption records.
- ☐ Juvenile Justice Information, e.g., arrest and criminal records, probation records, social and clinical studies, court reports, law enforcement records in general.
- ☐ Mental Health Information, Counselor reports, psychiatric and psychological diagnoses, reports and evaluations, and treatment recommendations.
- ☐ Education Information, e.g., to include standardized test scores, grades, report cards, attendance, IEP's, counseling, special education, learning disability and diagnoses related thereto, disciplinary, health, and social work records and reports.
- ☐ Medical Information, e.g., records and reports of patient history, diagnoses, evaluations, treatment, including those related to developmental disability (with the exception of HIV and AIDS related information.)
- ☐ Vocational Rehabilitation Information, e.g., records and reports of disabilities, evaluations, and recommendations.
- ☐ Alcohol and Substance Abuse Information, e.g., records and reports of alcohol and/or substance abuse.
- ☐ Other: _____
- ☐ **RECORDS NOT TO BE RELEASED** (Identify the record and a date range if applicable):

_____

I understand that the information and records I am authorizing release of are protected under Federal and State regulations governing confidentiality, including but not limited to, 42 CFR part 2, 45 CFR part 160, the Health Insurance Portability and Accountability Act (HIPPA) and the Family Educational Rights and Privacy Act (FERPA) and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that none of the agencies listed herein may condition my treatment on whether or not I sign this form.

The following agencies and individuals may participate and are included in the authorization.

- Colorado Healthy Partnership (funding source for Mental Health)
- Division of Youth Services
- Gunnison County Juvenile Services
- Gunnison County Sheriff's Office
- Gunnison Valley Mentors
- Gunnison Police Department
- Gunnison Valley Health
- Other: _____
- Gunnison-Hinsdale County Health and Human Services
- Gunnison Watershed RE-1-J School District
- Gunnison County Attorney
- Midwestern Colorado Mental Health Center
- 7th Judicial District Probation
- 7th Judicial District Attorney's Office
- Other: _____
- Other: _____

Purpose of Consent to Release: This Consent to Release is intended for the purpose of allowing the release of information critical to allow certain agencies to coordinate and manage the provision of service sot children and families who would benefit from integrated multi-agency services. This Consent to Release authorizes the sharing of information among the listed entities, many or all of which are authorized to view such information pursuant to applicable state or federal law.

This Consent to Release automatically ends one year from the date I sign this form, or when the sharing of information is no longer needed to manage or provide services to me, my child(ren), or wards, or when I revoke my consent, whichever is sooner, except to the extent that the program or person authorizes to make the disclosure has already acted in reliance on this consent. I understand I may revoke this authorization at any time by signing the revocation statement below and providing this document to the agencies listed in this Consent to Release. Agencies and providers who are listed in this Consent to Release and request information under this release may use a copy or facsimile (FAX) of this form in place of the original signed consent form. I agree that this information may be re-disclosed to all agencies listed if necessary to fulfil the purpose of the Consent to Release and understand the potential that such re-disclosure may mean the information or records are no longer protected by HIPPA.

This Consent to Release has been explained to me. I have read it (or it was read to me) and understand its provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to share of information as described above. I have received a copy of this Consent to Release.

Dated: _____

_____	_____	_____
(Signature of Parent, Guardian or Authorized Representative)	(Also Known As – AKA)	(Date of Birth)
_____	_____	_____
(Signature of Parent, Guardian or Authorized Representative)	(Also Known As – AKA)	(Date of Birth)
_____	_____	
(Person facilitating this Authorization)	(Title and Agency or Organization)	

NOTE: If you choose to modify or revoke this consent to release, you must sign below and provide to the appropriate agency/agencies.

I hereby ☐revoke / ☐modify as shown this Consent to Release: (check one)

_____	_____
(Signature)	(Date)