Inter-agency Community Action Collaborative (CAC)

**CONSENT TO DISCLOSE, SUBSTANCE ABUSE, MENTAL HEALTH TREATMENT, MEDICAL TREATMENT INFORMATION, AND CARE COORDINATION INFORMATION.**

This **Consent to Disclose** provides authorization for the disclosure of the protected health information of:

Client / Patient Name Date of Birth

**I consent to the disclosure of my use of services and treatment, including my mental health, substance abuse treatment information, medical treatment information, and care coordination information by and between the following members of the Community Action Collaborative partner, for the purposes of developing and accessing an individual care plan, and coordinating my care/treatment among Interagency Treatment Group members.**

The Community Action Collaborative partners include:

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| United Way of Weld County | North Colorado Medical Center |
| Greeley Transitional House | Intervention Community Corrections Services (ICCS) |
| Weld County Justice Services | Catholic Charities/GCC |
| North Colorado Health Alliance Greeley Municipal Courts | Weld County Sheriff’s Office Greeley City Attorney’s Office |
| Greeley Police DepartmentGreeley Fire Department | North Range Behavioral HealthA Woman’s Place |
| Greeley/Weld Housing Authorities | Weld Dept. of Human Services |
| The Arc of Weld County | Colorado Judicial – Probation Office |
| Envision | CDOC Division of Adult Parole High Plains Library District |

Members of the Interagency CAC have my permission to disclose, among themselves, my use of services and my mental health, substance abuse treatment information, medical treatment information, and care coordination information in **oral format only**. The information shared will solely be used to develop a treatment plan, assess the plan’s effectiveness, and to coordinate care. Written treatment records may not be disclosed without my separate written consent. No information shared between members of the Interagency CAC may be further disclosed to anyone outside the group, unless the client/patient signs a separate written authorization specifically consenting to such disclosure.

This consent is subject to revocation at any time, except to the extent that the members of the Interagency CAC have already taken action in reliance upon it. If not previously revoked, this consent will expire on (list specific date, event, or condition): \_

Client / Patient Signature Date

Parent or Legal Representative Signature (if Required) Date

Printed Name of Parent or Legal Representative Relationship, if not signed by Client / 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. Revised 09.14.16