AUTHORIZATION TO RELEASE EL PASO COUNTY DEPARTMENT OF HUMAN SERVICES RECORDS

NAME: _____

DOB: _____

SSN: _____

Please include a copy of your ID with this request.

RELEASE TO: (if not self)

DHS INFORMATION REQUESTED:

Records including referrals, case notes, assessments, copies of treatment or permanency plans, photographs, videos, facilitated meeting notes, and communications with other agencies or providers w*ith the exception of psychotherapy notes as that term is defined by HIPPA.*

_____ Children, Youth, and Family Services (TRAILS)

_____Release my records

_____Release my children's records

Names of children and their DOB:

_____

_____

_____ Adult Protective Services (CAPS)

_____ Other: (please specify):

_____

_____

In addition to above requested information, specific description of information or materials requested:

DATES COVERED OF ROI:

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____ At the request of the individual.

_____Other (e.g., legal/litigation):

In executing this authorization, I specifically waive any privilege or right of privacy as to any confidential communication between myself and any County employee which is contained anywhere in the above requested documents.

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the Requester, but in any event on: (date) or days hereafter, or under the following conditions if they occur prior to the specific expiration date set forth above:

NOTE: **If no expiration date is filled in above, this release will automatically expire 1 year from the date it is signed.**

OTHER CONDITIONS:

_____A copy of this Authorization or my signature thereon may be used with the same effectiveness as an original.
_____Copies of records to be supplied to other counsel in the matter are authorized.
_____Other: _____

To the extent Protected Health Information is included in the above requested documents, the following HIPAA-required statements apply:

I understand that non-research related medical treatment may not be conditioned upon signing this release.

I understand that the information provided under this release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA privacy rules

I understand that I may revoke this release at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must provide written notice to the provider named in this release and written notice to the organization or entity to whom I have authorized the release of information.

This release does not authorize the release or disclosure of psychotherapy notes as that term is defined by HIPPA.

PLEASE NOTE THAT THE EL PASO COUNTY RECORDS DEPARTMENT IS NOT THE CUSTODIAN OF ALL REPORTS/DATA/RECORDS YOU MAY BE SEEKING. DHS WILL NOT RELEASE ANY 3RD PARTY DOCUMENTS SUCH AS POLICE REPORTS, HOSPITAL RECORDS, COURT RECORDS, ETC. PLEASE CONTACT THE CUSTODIAN OF RECORDS FOR ANY SUCH INFORMATION.

TODAY'S DATE: _____

ORIGINAL CLIENT SIGNATURE:

_____

PERSON(S) YOU ARE AUTHORIZED TO SIGN FOR (LIST ALL MINORS)

_____

_____ _____

YOUR RELATIONSHIP: _____

*Electronic signatures are not permitted.
*If anyone other than the subject of the records is signing as an authorized signer. **Written verification of guardianship or custody must be provided.**
*Minors (under 18) cannot sign for themselves.