Northeast Behavioral Health Partnership, LLC 1300 N. 17th Avenue Greeley, CO 80631
phone 970-347-2622 fax 970-392-1354 toll free 1-888-296-5827

Authorization for Use or Disclosure of Medical Information

Read this information first: You should complete this form if you want to authorize Northeast Behavioral Health Partnership (NBHP) to use or disclose your medical information to persons who may or may not directly be involved in making decisions about your health care. This authorization will remain in effect until (a) the date you specify, up to one (1) year; (b) one (1) year from date signed; or (c) the date you cancel your permission.

After completing this form, follow the instructions of the person who gave you this form, or send it to NBHP (see top of page).

Step 1: Tell us about yourself (or the person receiving services, if a minor). This will help us find that person's records:

1. _____ 2. __ __ / __ __ / __ __ __ __
Name Date of Birth

3. _____ 4. (__ __ __) __ __ __ - __ __ __ __
Address Phone Number

Step 2: Tell us what medical information may be used or disclosed, to whom, and for how long:

5. Check the box to tell us what information may be used or disclosed:

☐ My entire record ☐ Other (please specify) _____

6. Check the box to indicate purpose of the use or disclosure:

☐ At my request ☐ Other (please specify)_____

Step 3: Tell us who you are authorizing to use or receive your medical information. You can ask anyone to act on your behalf.

7. _____
Name of Authorized person Address / Telephone of Authorized person

8. Relationship to Authorized person: _____

9. **OPTIONAL:** Date you want this authorization to end: __ __ / __ __ / __ __ __ __

Step 4: In completing this form (authorization) you understand that:

- You have the right to look at the information that is being used or disclosed;
- You do not have to fill out the authorization. If you decide not to fill out the form, it will not affect your benefits unless this authorization is necessary to make decisions about your benefits;
- If you sign this form, NBHP does not have control over how others use your information. If someone else discloses private information about you, you may no longer be protected by federal privacy laws.
- You have a right to cancel this authorization at any time by completing Step 5; the "Cancellation of Authorization" Section at the bottom of this form. After you have filled it out and signed it, send it to NBHP. You may call NBHP to ask for a cancellation at 1-888-296-5827.
- You have a right to get a copy of this signed authorization.

10. _____ _____
Signature of person receiving services Date

(Note: Minor children must sign a release at age 15 or older. Parents cannot sign for children age 15 or older.)

11. _____ _____
Signature of Parent and/or Guardian (if applicable) Date

12. _____ _____
Witness signature Date

Step 5: Cancellation of Authorization: If you do not want the person you named in Step 3 to continue to use or disclose your medical information, you may cancel your permission for them to do so. This section needs to be completed and sent to Northeast Behavioral Health Partnership.

I hereby cancel my consent for this Authorization to Use or Disclose Medical Information.

_____ _____
Consumer signature Date Witness signature Date