Pueblo Interagency Oversight Group
AUTHORIZATION TO REQUEST AND RELEASE INFORMATION
(Alcohol and Drug Abuse Patient Records)

The Pueblo Interagency Oversight Group is made up of a group of professionals from other agencies who work closely together to provide the best possible treatment and assistance. The professionals request the ability to share information among the agencies listed below to help coordinate treatment and help achieve the family's goals.

I, _____, _____,
(First, Middle, and Last Name) (Relationship to Child/Ward)

on behalf of myself and/or my following children and/or wards,

_____, _____, _____,
(First, Middle, and Last Name of Child/Ward) (Date of Birth) (SSN)

_____, _____, _____,
(First, Middle, and Last Name of Child/Ward) (Date of Birth) (SSN)

authorize the agencies listed below to request from each other, and share with each other, the following alcohol and drug abuse treatment information:

_____ Alcohol/drug use history
_____ Consultation reports
_____ Transition plan
_____ Treatment discharge summary
_____ Court history and reports
_____ Urinalysis results
_____ Other: _____

_____ Assessment/evaluation reports
_____ Progress/compliance reports
_____ Family history and social information
_____ Alcohol/drug abuse treatment summary
_____ Psychiatric history and treatment summary

The information described above may be confidential under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 ("Part 2"), and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164. I understand that, unless otherwise permitted by Part 2 and HIPAA, such records cannot be disclosed without my prior written consent. I understand that none of the agencies listed below may condition my treatment on whether or not I sign this Authorization.

Some of the agencies listed below already may have legal access to the information described above regardless whether I sign this Authorization.

The agencies listed below may re-disclose the information described above to each other if necessary to carry out the purposes of this Authorization.

This Authorization shall expire upon completeion of my or my family's involvement with the identified agencies, or when revoked by me. I understand I may revoke this Authorization at any time by signing the revocation statement below and providing this document to the agencies to which my revocation applies. Agencies listed below may use a copy of this form in place of the original.

This Authorization has been explained to me. I have read this Authorization (or it was read to me) and I understand it. I have been given a reasonable amount of time to ask questions and consider whether to sign this Authorization. I willingly agree to the sharing of information as described above. I have received a copy of this Authorization.

NOTE: If a youth or adolescent authorizes the information described above to be disclosed to his or her parent or guardian, the youth or adolescent must sign a separate Authorization for that purpose.

Signature of Youth or Adolescent (Also need signature of Parent, Guardian, or Authorized Representative if under 14 years of age)	Signature of Parent, Guardian, or Authorized Representative
Date	Date

Staff Use Only

Signature of Staff Person Facilitating Authorization	Title
Agency	Date

Modification or Revocation

NOTE: If you choose to modify or revoke this Authorization, you must sign below and provide a copy of your revocation to the appropriate agencies.

___ I hereby modify this Authorization as follows: _____

_____

___ I hereby revoke this Authorization.

_____
Signature

_____
Date

Pueblo Interagency Oversight Group
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Participating Agencies

Effective Date:
List Revised:

Pueblo County Department of Social Services
[address]

10th Judicial District – Courts
[address]

10th Judicial District – Probation
[address]

Pueblo School District 60
[address]

Spanish Peaks Mental Health Center
[address]

Catholic Charities of the Diocese of Pueblo
[address]

Pueblo Interagency Oversight Group
[address]

Divison of Youth Corrections
[address]

Crossroads Turning Points (Signal)
[address]

Other Agencies for Purposes of this Authoriztion:

_____
_____
_____
_____
_____
_____