COLORADO
Department of Corrections

AR Form 950-02A2 (03/16/20)

Authorization for Use and Disclosure of Behavioral Health Information

Offender Name	DOB	DOC#	
I authorize the Colorado Department of Corrections to disclose to:			
Name	Phone Number	Company	
Address	City	State	ZIP
and/or I authorize (other facility) to disclose to the DOC facility:			
Address:	Phone	Requested by:	

	Urgent request for offender care fax to:
	Routine request for offender care mail to address above

I authorize the following information to be released and/or disclosed:	Up to date of service:
	Behavioral Health:
	Other:

The purpose of this disclosure is to be used for: _____Continuity of Care _____Legal Purposes
At the request of the individual________________Other:____

I understand that:

- The he information disclosed may contain testing information or treatment information relating to Behavioral / Mental Health; Sexually Transmitted Diseases; HIV/AIDS virus.
- Once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulations.
- This authorization will be valid for the duration of the incarceration plus 90 days after release.
- This authorization expires upon the individual's death.
- This form may be revoked at any time providing that the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the health records custodian.
- DOC may not use as a condition of treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization except as allowed by law.
- I am entitled to a copy of this signed authorization.
- By signing I acknowledge I have _____inspected or _____ have received a copy of requested records.

Printed Offender Name	Offender Signature	Date
Printed Name of Person Authorized to Sign for Offender	Signature of Person Authorized to Sign for the Offender	Date
DOC Employee Signature		Date

Attending Mental Health Provider's Acknowledgement of Offender's Request for Access to Mental Health Records:
I hereby acknowledge the request of the above named offender to ___ inspect and/or ___ receive photocopies of health record. The records ___ do **or** ___ do not contain information relating to psychiatric problems or doctors' notes which, if revealed to the offender, would have a significant negative psychological impact upon him/her. If access is denied, please contact the chief of behavioral health services.

Signature of Mental Health Provider Date