2555 Midpoint Drive, Suite A, Fort Collins, Colorado 80525-4425, 970.498.7530, Larimer.org/cjs/comcor/programs 810 East 10th Street, Suite 130, Loveland, Colorado 80537-4946

AIIM Program - Pre-Screen Release Of Information

Client Name (printed):	Date of Birth:
(listed below) can talk to your medical and mental health to each other about you in order to see if you are a good you to sign their own releases before they will share info	g this release, you are agreeing that the AIIM Program partners providers (including substance abuse treatment providers) and fit for the AIIM Program. Some of those providers might ask rmation for this assessment. Also, if you are accepted for a full you have any questions about this process, talk to your attorney
Authorization for the Rec	eipt and Exchange of Information
Corrections, SummitStone Health Partners, Colorado Stathe 8th Judicial District Probation Department, Fort Collin County Sheriff's Office, Colorado State University Police receive and exchange the information about me listed be	orize the AIIM Program partnership (Larimer County Community ate Public Defenders' office, 8th Judicial District Attorneys' office as Police Department, Loveland Police Department, Larimer Department) and
	ent records which includes mental health condition and
consultation reports and notes, outpati and (write in additional items)	st reports, test data, notes of Progress-to-Date, ent records, correspondence related to clinical matters,
them either verbally or in writing, and that I am authorizir AIIM Program assessment process.	ng them to give opinions and answer questions as part of the
treatment information: Includes all information regardidrug abuse or alcohol abuse. I agree that any drug or all	includes, if any, alcohol and substance abuse condition and any assessment, diagnosis, referral, history, or discussion of loohol treatment provider can discuss any communications that I I am authorizing them to give opinions and answer questions as
and state confidentiality regulations. I also understand the mental health, and treatment information confidential underlease of drug abuse and/or alcohol abuse information the Law [42 CFR, Part 2]. This information cannot be disclosorovided for in the regulations. I understand that I may result the content of the conte	ual(s) or agencies listed above may be protected under federal nat the AIIM Program partners are obligated to keep my medical der their guidelines. I understand that if I have authorized the that the confidentiality of this information is protected by Federal sed without my written consent, unless otherwise specifically evoke this consent at any time. Copies of this form may be used release form may be sent to the agencies and persons identified is release may also be communicated via email or fax.
This consent expires:	(two years, or sooner, from date of this release).
Client:	Date:
	Date:
Notice to recipient: This information has been disclosed to Federal Regulations (42 CFR, Part 2) prohibit you from maken	you from records whose confidentiality is protected by Federal Law. king further disclosure of it without the specific written consent of the ch regulations. A general authorization for the release of medical o
Consent revoked:	Date:
Witness:	Date:

