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:** _____

You have been referred to the AIIM Program. By signing this release, you are agreeing that the AIIM Program partners (listed below) can talk to your medical and mental health providers (including substance abuse treatment providers) and to each other about you in order to see if you are a good fit for the AIIM Program. Some of those providers might ask you to sign their own releases before they will share information for this assessment. Also, if you are accepted for a full evaluation, you will be asked to sign further releases. If you have any questions about this process, talk to your attorney.

Authorization for the Receipt and Exchange of Information

I, _____, hereby authorize the AIIM Program partnership (Larimer County Community Corrections, SummitStone Health Partners, Colorado State Public Defenders' office, 8th Judicial District Attorneys' office, the 8th Judicial District Probation Department, Fort Collins Police Department, Loveland Police Department, Larimer County Sheriff's Office, Colorado State University Police Department) and _____ to receive and exchange the information about me listed below. I also understand that my criminal history and probation history will be reviewed by the partners as part of this assessment process. The information can be received and exchanged in writing or verbally.

(Initial) _____ **All medical and mental health treatment records which includes mental health condition and treatment, for all dates of treatment:** Including, but not limited to (initial all that apply)
_____ clinical charts, _____ office notes, _____ test reports, _____ test data, _____ notes of Progress-to-Date, _____ consultation reports and notes, _____ outpatient records, _____ correspondence related to clinical matters, and _____ (write in additional items) _____.
I agree that any medical and mental health treatment provider can discuss any communications that I have had with them either verbally or in writing, and that I am authorizing them to give opinions and answer questions as part of the AIIM Program assessment process.

(Initial) _____ **Drug abuse or alcohol abuse, which includes, if any, alcohol and substance abuse condition and treatment information:** Includes all information regarding any assessment, diagnosis, referral, history, or discussion of drug abuse or alcohol abuse. *I agree that any drug or alcohol treatment provider can discuss any communications that I have had with them either verbally or in writing, and that I am authorizing them to give opinions and answer questions as part of the AIIM Program assessment process.*

I understand that my records and/or those of any individual(s) or agencies listed above may be protected under federal and state confidentiality regulations. I also understand that the AIIM Program partners are obligated to keep my medical, mental health, and treatment information confidential under their guidelines. I understand that if I have authorized the release of drug abuse and/or alcohol abuse information that the confidentiality of this information is protected by Federal Law [42 CFR, Part 2]. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time. Copies of this form may be used instead of the original. I understand and agree that this release form may be sent to the agencies and persons identified above. I also understand that information covered by this release may also be communicated via email or fax.

This consent expires: _____(two years, or sooner, from date of this release).
I understand that I can revoke this consent at any time in writing.

Client: _____ Date: _____

Witness: _____ Date: _____

Notice to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Consent revoked: _____ Date: _____

Witness: _____ Date: _____