AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be filled out completely to be valid.

Member Name:_____ Member ID:_____

I give Colorado Access and the person/organization listed below permission to exchange and share my health information

_____	_____	_____	
Name	Phone number	Fax number	
_____	_____	_____	_____
Address (optional)	City	State	Zip code

Please make selections in the following three (3) sections:

My information may be shared for the following purpose (you must mark a selection):

☐ Care coordination/treatment
☐ To explain benefits and coverage
☐ Legal representation
☐ Grievance and/or appeal representation
☐ At my request
☐ Other _____

By marking one (1) of the boxes below, I give permission to share the following information:

☐ All health records

OR

☐ Only limited information may be shared (select the information you would like to share below).

_____ Billing and claims information/Prior authorizations
_____ Eligibility information
_____ Case management notes/plans
_____ Demographic information
_____ Other - please specify _____

Specific health information will not be shared, unless I select this information below:

_____ HIV/AIDS related information and/or records
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment and referral information

The information to be shared covers the following dates of service: _____

My permission will expire one (1) year from the date this authorization is signed, unless I change my permission below: Specific date of expiration: ___/___/___(MM/DD/YY) not to exceed two (2) years.

Authorization Statements

I am voluntarily signing this authorization. I understand that I may refuse to sign this authorization. If I refuse to sign this authorization my health care benefits or payment for my healthcare benefits will not be affected.

I may cancel this authorization at any time. To cancel this authorization, I may call Colorado Access at 855-879-8286, TTY/TDD users call 888-803-4494 or send an email to privacy@coaccess.com. I understand that if I cancel this authorization, it will not affect information that was shared before Colorado Access received my written cancellation.

I understand that if I give Colorado Access permission to share my information, the people or organizations who receive my information may not be required to protect my information.

_____ _____

Signature of the member or personal representative Date

_____ _____

Print the name of the member's personal representative Date

_____

Description of personal representative's authority

Personal Representatives: If you are signing this authorization on behalf of a member, you must include documentation that supports your authority to make health care decisions on behalf of the member.

Minors: Minors 15 years and older may authorize the release of mental health information by signing this form. Minors of any age may authorize the release of health care information related to the treatment of sexually transmitted diseases, including HIV/AIDS, alcohol and/or drug abuse treatment, contraception treatment, and prenatal care services by signing this form.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.