Department of Health Care Policy & Financing

AUTHORIZATION TO DISCLOSE INFORMATION

To allow a THIRD PARTY to have access to Protected Health Information

CLIENT INFORMATION:

Client Name: _____ Date of Birth: _____

State ID #, Client+ #, or Social Security #: _____
Used for identity verification purposes only

Address, City, State, Zip: _____

The Colorado Department of Health Care Policy and Financing is authorized to disclose my Protected Health Information as specified below to the following person or organization:

Name: _____ Phone Number: 303-839-1775 fax: 303-648-6262

Organization: Colorado Cross-Disability Coalition

Address, City, State, Zip: 1385 S. Colorado Blvd., Suite 610-A, Denver, CO 80222

INFORMATION TO BE PROVIDED:

- ☐ Information related to eligibility for benefits – including information located within the Colorado Benefits Management System
- ☐ Information related to claims, payment, or lack of payment for health care treatment
- ☐ Health care options, customer service assistance
- ☐ Other:
- ☐ For a specific time period – From: To:

PURPOSE OR NEED FOR INFORMATION BEING REQUESTED: (If you prefer not to state a purpose, please state "At the request of the individual")

EXPIRATION OF AUTHORIZATION: This Authorization will expire in one year from the date signed below, unless another date or event is listed.

Department of Health Care Policy & Financing

REQUIRED STATEMENTS:

I understand that the information provided based on this Authorization may be redisclosed to another party by the authorized recipient, and that the Colorado Department of Health Care Policy and Financing has no control over that additional disclosure and can not protect the information after it is released based on this Authorization.

I understand that I may revoke this Authorization at any time in writing to the address below. I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions take or disclosures made while the authorization was in effect.

I understand that the Colorado Department of Health Care Policy and Financing may not condition my health care treatment or payment, or my enrollment or eligibility for benefits on my executing this Authorization.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

Client signature: _____ **Date:** _____
Parent or Legal Guardian may sign on behalf of minor child.
Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult – documentation is required.

Return Completed Form by fax or mail to:
Benefits Coordination Section
Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203
Fax: (303) 866-3552