NON-ATTORNEY AUTHORIZATION

For the Use and Disclosure of Protected Health Information during the Appeal Process

Return to: Office of Administrative Courts
633 17th Street, Suite 1300, Denver CO 80202

***** This form must be completed and returned immediately if someone will be assisting you in the appeal process *****

The Health Insurance Portability and Accountability Act of 1996 states that your protected health information may not be shared without your permission, except in certain situations. If you sign this form, you are giving permission to the Colorado Department of Health Care Policy and Financing and to the Office of Administrative Courts to share your protected health information. This does not protect the information from being shared with more people once it has been disclosed.

The Colorado Department of Health Care Policy and Financing may not condition treatment, payment, enrollment or eligibility for benefits on whether you execute this authorization.

You may request a copy of this authorization and may revoke/cancel your authorization at any time during the appeal process. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect.

I, _____ (client or applicant name) **authorize the Colorado Department of Health Care Policy and Financing (Department), as well as the Office of Administrative Courts, to share my protected health information and other confidential information gathered by, or on behalf of, the Department to determine my eligibility for services or enrollment in a Colorado Medical Assistance Program.**

My address is: _____

My information may be shared with the following person(s) and/or entity who will represent or assist me in the appeal process:

_____

Address: _____

My information may only be shared, disclosed, or used to further and assist in my appeal. This Authorization will expire at the conclusion of the appeal process.

Signature: _____ Date: _____
Parent/Legal guardian may sign on behalf of minor child

Date of birth: _____ Medicaid ID # or Social Security #: _____

Name of Designated Personal Representative: _____
Legal documentation must be included to show authority to sign on behalf of client or applicant, if client/applicant is not signing on his/her own.

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____