

**Colorado Indigent Care Program
Client Authorization
For the Use and Disclosure of Protected Health Information**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 states that we cannot share your protected health information without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, to determine enrollment or eligibility for benefits, or for health plan operations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event.

If you decide later that you do not want us to share your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form and returning it to Colorado Department of Health Care Policy and Financing, Special Financing Division. 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. See the Department's Privacy Policies and Procedures on Use and Disclosure of Protected Health Information – Authorization Required, pursuant to 45 C.F.R. 164.508.

Date: _____

**I, _____ (print your name)
authorize the following person or group to disclose my protected health
information with the Colorado Department of Health Care Policy and
Financing:**

The following information may be disclosed:

Information related to eligibility for benefits for the following time period (specify dates):

From: _____ To: _____

Information including claims, reports and other documents related to claims for benefits from a certain time period (specify dates):

From: _____ To: _____

Information relating to payment or lack of payment of benefits for services rendered on a specific date:

Date: _____

Name of health care provider: _____

Other (specify): _____

Purpose of request for information: (If you prefer not to state a purpose, please state "At the request of the individual") _____

Expiration of authorization: (You must specify a date or event, i.e., at the end of litigation)

Date / event of expiration: _____

Covered entities under HIPAA may not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

Name: _____

Signature: _____

Date of birth: _____ Social Security: _____

Name of Designated Personal Representative: _____

Legal documentation must be included to show authority to receive information

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____

This form must be received by the Department's Colorado Indigent Care Program prior to any discussion with a third party (i.e. hospital, clinic or billing agent) a client's eligibility for benefits; information including claims, reports, and other documents related to claims for benefits; or information relating to payment or lack of payment of benefits for services rendered. Without this form, the Colorado Indigent Care Program will not discuss any client specific issues with any provider or outside agent.

Return completed form to cicpcorrespondence@state.co.us