

NON-ATTORNEY AUTHORIZATION

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

Return with Request for State Hearing to: Office of Administrative Courts
633 17th Street, Suite 1300, Denver CO 80202

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

The Health Insurance Portability and Accountability Act of 1996 states that we cannot share your protected health information without your permission, except in certain situations. 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.

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 by notifying the Office of Administrative Courts in writing at the above address. 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 potential client name) **authorize the Colorado Department of Health Care Policy and Financing, Office of Appeals, as well as the Office of Administrative Courts, to share my protected health information and other confidential information gathered by 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:

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 potential client ***

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____