COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

Interview and Photography Authorization

In consideration of my participation in an interview, testimonial, photograph or video (CIRCLE ALL APPLICABLE) for the Colorado Department of Health Care Policy and Financing, I hereby consent to the publication, reproduction, distribution or other use by the Department their successors and assigns, of my name, photograph, likeness, words, voice and/or personal health information* for broadcasting, commercial, advertising, public service announcement, trade or any other purpose relating to promoting the Department's programs and/or benefits.

I am the age of majority or greater, or if a minor, the authorization has been signed and ratified by my legal guardian.

I understand that the information provided based on this Authorization may be re-disclosed 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 cannot protect the information after it is released based on this Authorization.

This authorization expires when the Department is no longer using the interview/testimonial/video/picture as per this Agreement, or when the Client revokes it in writing. I understand that I may revoke this Authorization at any time in writing to the address above. 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 Printed Legal Name Client signature

_____

Address (Please print)

_____

Telephone Number

_____ _____

Date Parent or legal guardian signature

Parent or legal guardian may sign on behalf of minor child.
Legal Guardian, Medical Power of Attorney, or equivalent may sign on behalf of adult – documentation is required.

Return Completed Form by fax or mail to:
Communication Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203
Fax: (303) 866-4411

*NOTE: Personal health information may include, but is not limited to, protected health information such as details about physical health, mental health and experiences with the health care system.