700 Columbine St., Sterling, CO 80751 - (970) 522-3741 – (877) 795-0646 - www.nchd.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: ______________________________________ Date of Birth: __________________________

Address: ____Phone: _______________________________

I authorize _____________________________________ (agency/provider) to use and disclose protected health

information to ____ (agency/provider).

This authorization is valid covering the period(s): From (date) _________________ to (date) __________________

☐ I authorize the **release (requesting)** of specified medical records
☐ I authorize the **disclosure (sharing)** of specified medical records

Types of records authorized to release: ____

This information is to be released to (provider/agency): ____

____ _________________________ __________________________
Address Phone Fax

The information is to be disclosed for the following purposes: (choose one)
☐ At my request OR ☐ Other (please specify)____

I understand that: The Northeast Colorado Health Department may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that my health information may potentially be re-disclosed by the recipient identified in this authorization. Northeast Colorado Health Department is not responsible for any such disclosures. Northeast Colorado Health Department and its workforce are released from any legal responsibility or liability for disclosures made pursuant to this authorization.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless revoked, this authorization will expire on the above date, event or condition listed: ____

____ ______________________________
Signature of Patient or Legal Representative Date

Description of authority of Representative to act on behalf of the patient: ____________________________