AUTHORIZATION TO EXCHANGE, COMMUNICATE, USE, OR DISCLOSE
MEMBER PROTECTED HEALTH INFORMATION

I give my permission for the use, communication, and/or disclosure of my health information and/or medical records as described below. I understand that my permission is voluntary and if I do not give my permission my healthcare will not be affected. I understand that if the person or organization that I give permission to receive my information is not a health plan or healthcare provider, the information that is disclosed may no longer be protected by federal privacy regulations. **This form must be filled out completely for all authorizations.**

Member Name:_____ Address: _____

Member ID (SSN or Medicaid ID#): _____ _____

I authorize the exchange, use, communication, and/or disclosure of my health information and/or medical records by and between:

☐ Colorado Access Advantage		_____
☐ Access Health Colorado		_____
☐ Access Behavioral Care	AND	_____
☐ CHP+ offered by Colorado Access		_____
☐ CHP+ State Managed Care Network		_____
☐ Behavioral Healthcare, Inc.		_____
☐ Regional Care Collaborative Organization		_____
☐ Access Long Term Support Solutions		_____
☐ AccessCare Services		_____

By initialing the spaces below, I give my permission for the use , communication, and/or disclosure of the following health information and/or medical records:

____ Medical records or health information
____ Billing information
____ Emergency and urgent care records
____ Laboratory reports
____ Medical history and treatment
____ Other - specify _____

____ Medications
____ Psychiatric history
____ Treatment plan
____ Treatment discharge summary
____ Personal identifying information

You must individually initial the following types of health information in order for such information to be included in the use, communication and/or disclosure of other health information as indicated above:

____ HIV/AIDS related information and/or records
____ Psychotherapy notes
____ Genetic testing information and/or records
____ Sickle cell anemia related information and/or records
____ Drug/alcohol diagnosis, treatment and referral information (this release does not include records protected under Federal Regulation 42 CFR Part 2). Describe how much and what kind of information:_____

_____

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The health information that is to be used and/or disclosed covers the following dates of service (check one):

☐ All dates of service

☐ Specify which dates of service apply: _____

I understand that if the information used, disclosed, or communicated pursuant to this authorization is redisclosed, it may no longer be protected under federal privacy regulations. I also understand that federal or state law may restrict redisclosure of substance use and mental health related diagnosis and treatment information. I understand that my ability to receive health care services or reimbursement for services will not be affected if I do not sign this authorization. I understand that I have a right to a copy of this authorization.

You may withdraw this authorization in writing at any time. If you withdraw this authorization the information described above shall no longer be used or disclosed for the purposes laid out in this authorization. A withdrawal will not stop information that has already been used, disclosed, or communicated pursuant to this authorization. To withdraw this authorization please send a written statement to the organizations that you gave permission to use and disclose your health information, as listed on the first page of this authorization.

Unless withdrawn, this authorization will expire on ___/___/___ (MM/DD/YY)

I certify that I authorize the use of my health information as set forth in this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization in its entirety.

Signature of the member or personal representative	Date
Print the member's name	Print the name of the member's personal representative
Description of personal representative's authority	

If you have authority to sign on behalf of a member, you must include documentation that supports your authority. All references to "member" in this authorization include a patient, client, or beneficiary, as applicable.