

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 an	nd disclose protected health	
information to	(agency/p	(agency/provider).	
This authorization is valid covering	g the period(s): From (date)	_ to (date)	
☐ I authorize the <b>release (reques</b> ☐ I authorize the <b>disclosure (sha</b> ☐			
Types of records authorized to rele	ease:		
This information is to be released	to (provider/agency):		
Address	Phone	Fax	
	for the following purposes: (choose one) r (please specify)		
I understand that: The Northeast or eligibility for benefits on whether	Colorado Health Department may not condition er I sign this authorization.	treatment, payment, enrollment	
authorization. Northeast Colorado	mation may potentially be re-disclosed by the reconstruction. Health Department is not responsible for any so its workforce are released from any legal responsen.	uch disclosures. Northeast	
	ny be revoked in writing at any time, except to the tion. Unless revoked, this authorization will expir		
Signature of Patient or Legal Repre	esentative Date		
Description of authority of Repres	sentative to act on behalf of the patient:		