HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Insured/Member Name: _____ ID No. _____

I hereby authorize the use or disclosure of my health information while I am participating in County Health Pool.

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the CHP Privacy Officer, 800 Grant St., Suite 400, Denver, CO 80203, (303) 861-0507. A revocation is only effective after it is received and logged by County Health Pool, and any use or disclosure made prior to a revocation under this authorization will not be affected by a later revocation.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to further disclosure by the recipient and would no longer be protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is for treatment related to research.
- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- I am entitled to receive a copy of this authorization.

This authorization is effective from the date signed below until I terminate coverage through County Health Pool.

_____ _____

Signature of Insured/Member or Personal Representative Date

Printed Name of Personal Representative: _____

Relationship to Insured/Member: _____