HIPAA INDIVIDUAL AUTHORIZATION

Colorado HealthOP™

Member Information (to be completed by member)

Last Name	First Name	M.I.

Member ID Number (As on ID card)	Member ID Number (As on ID card)

Date of Birth	Daytime Phone Number	Social Security Number

Home Address (P.O. Box not accepted unless rural P.O. Box)	Apt. No.

City	State	Zip Code

Part A:

I authorize the following person or types of people to disclose my information:
Colorado HealthOP, its affiliates and any of its agents

Part B:

I authorize the following person to receive my information
(the person receiving the information must be 18 years of age or older):

Name	

Relationship to the Member	Age

Part C:

I authorize the following information to be used or disclosed on my behalf (check one block):
Colorado HealthOP, its affiliates and any of its agents

☐ All my information including health (e.g. diagnosis, claims, provider) and financial information (e.g. premium information) may be disclosed

OR

☐ Only limited information may be disclosed (check all applicable blocks below).

Limited Information

- ☐ Appeal
- ☐ Benefits & Coverage
- ☐ Billing
- ☐ Claims & Payment
- ☐ Diagnosis & Procedure
- ☐ Eligibility & Enrollment
- ☐ Financial
- ☐ Medical Records (excludes psychotherapy notes*)
- ☐ Physician & Hospital
- ☐ Pre-certification & Pre-authorization
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Behavioral Health
- ☐ Other: _____

Questions? Concerns? Please call Provider Services and we will be happy to help: 866-785-7265

☐ I authorize the release of the following types of sensitive information (check all blocks that apply):

- ☐ Abortion
- ☐ Abuse (sexual, physical, mental)
- ☐ Alcohol / substance
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted or other communicable diseases
- ☐ Other: _____

Part D:

The purpose of my authorization is (check one):

- ☐ To disclose the information at my request
- ☐ Other (Please explain) _____

Part E:

Expiration Date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- ☐ The date my coverage ends (only if disclosure requested by insurance company); or
- ☐ One year from the signature date below; or
- ☐ Upon the following date, event or condition (within the one year time frame):

Part F:

I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Member Signature (required for processing)
By signing below, I give my healthcare provider permission to mail or fax this form to the address or fax number listed below.

Signature _____ Date _____

Designated Legal Representative / Guardian

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal Representative / Guardian _____ Legal Relationship to Individual _____

Signature _____ Date _____

*Note This form cannot be used for psychotherapy notes. If you seek to authorize the use of disclosure of psychotherapy notes, then you will need to do so using a separate form.
Please keep a copy of this form for your records.

Please send this form to our secure FAX line:
610-374-6986

You can also mail to:
P.O. Box 14327
Reading, PA 19612
service@cohealthop.org

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