FORM A: Authorization to Release and Share Protected Health Information *(PHI)*

Is there anyone in your extended support network – such as friends, family, legal guardians or your power of attorney (POA) – that you would like us to be able to talk to? If not, that's ok.

I hereby consent to and authorize the Brain Injury Association and its employees, to obtain from and share individually identifiable protected health information with the individuals/organizations listed below. I understand that this authorization is voluntary. I understand that if the individuals/organizations authorized by this release to receive or share my information is not a health plan or health care provider, the released information may be subject to re-disclosure and no longer protected by federal privacy regulation.

Applicant Information *(person applying for Brain Injury Association Services) Please list additional contacts on a separate page.*

Name: _____ Date of Birth: ____/____/____

Secondary Contacts *(individuals/organizations authorized to release & share information, for example friends, family members, guardians or POA)*

For youth, please list parents info here.

Name: _____ Name: _____ Name: _____

Phone: _____ Phone: _____ Phone: _____

Relationship: _____ Relationship: _____ Relationship: _____

Purpose of Information Disclosure: *Services through the Brain Injury Association of Colorado*

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that unless I specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section found below. I further understand that any release of information prior to the rescinded date is legal and binding. This authorization will expire two (2) years from the date of signature on this application **unless you tell us that it should expire sooner.** I also understand that I may refuse to sign this authorization and that my services will not be affected if I do not sign. I further understand that I may request a copy of this signed authorization and that I may see and copy the information described on this form if I ask for it.

Signature: _____ Date: ____/____/____ Witness: _____
(Applicant/Guardian/POA Signature) *(If Required)*

Revocation Section *(Unless you would like to TAKE AWAY the above privileges, please do not sign.)*

I no longer authorize the above named parties to release and share my Protected Health Information.

Signature: _____ Date: ____/____/____ Time: _____
(Applicant/Guardian/POA Signature)