BRAIN INJURY ASSOCIATION OF COLORADO

7900 E Colfax Ave Ste. B, Denver, CO 80220
303.355.9969 | info@BIAColorado.org | BIAColorado.org
The Brain Injury Association of Colorado is a 501c3 nonprofit. EIN 84-0893049

Authorization to Release Protected Health Information

First Name: _____ Middle Initial: ___ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Date of Birth:_____

I AUTHORIZE

Brain Injury Association of Colorado
7900 E. Colfax Ave. Ste. B
Denver, CO 80220
Phone: 303-355-9969 Fax: 303-355-9968

To: ☐ release information to; ☐ obtain information from; ☐ exchange information with the person/organization(s) in section 3.

ORGANIZATION(S) / INDIVIDUAL(S) INFORMATION
Organization and/or Person Name: _____

Relationship to Patient (if applicable):_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

INFORMATION TO BE RELEASED
☐ All health information

☐ Only the types of information/records checked below (check all that apply)

☐ Billing records	☐ Clinical assessment(s)	☐ Continuity of care
☐ Demographics	☐ Diagnosis list	☐ Discharge summary
☐ Education plan	☐ Education records	☐ Employment info
☐ Laboratory results	☐ Medication history/orders	☐ Parole/Probation

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☐ Physician summaries ☐ Progress summaries ☐ Psychological testing
☐ Psychiatric evaluations

PURPOSE FOR DISCLOSURE:

I UNDERSTAND THAT:

- My health information is protected by federal regulation (Alcohol Drug Abuse Patient Records, 42 CFR Part 2, and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Brain Injury Association of Colorado's Privacy Notice.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on the Brain Injury Association of Colorado's Privacy Notice as it outlines the procedure for revocation. This authorization will expire one year from the date I sign or unless I request an earlier expiration in writing indicated here:_____.
- My treatment, payment, enrollment or eligibility may not be conditioned on my agreement to sign an authorization.
- Communications resulting from this authorization will reveal that I receive services at the Brain Injury Association of Colorado.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA requires Brain Injury Association of Colorado to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- This authorization may be used by the Brain Injury Association of Colorado owned or managed programs upon transfer of my care to them.

SIGNATURE

Patient's Signature: _____ Date:_____

OR Authorized Representative's Signature: _____ Date: _____

Representative's Name (printed): _____

Representative's Relationship to Patient:_____