AUTHORIZATION FOR USE AND RELEASE OF PROTECTED HEALTH INFORMATION

I _____ (Employee Name) hereby authorize the use or disclosure of my protected health information as described in this authorization.

(1) Specific person/department (or class of persons) authorized to provide the information: _____
_____
_____

(2) Specific person/organization (or class of persons) authorized to receive and use the information: _____
_____
_____

(3) Specific and meaningful description of the information: [For example, medical examination report, information regarding a health insurance claim or health insurance enrollment] _____
_____
_____

(4) Purpose of the request: [Please state the purpose of the request. If you do not wish to state a purpose, please state, "At the request of the individual."] _____
_____
_____

(5) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying Larimer County Human Resources in writing at 200 W. Oak, Suite 3200, Fort Collins, CO 80521. I understand that the revocation is only effective after it is received and logged by Human Resources. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

(7) I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization Larimer County requests.

(8) I understand that I am entitled to receive a copy of this authorization.

(9) I understand that this authorization will expire when my employment with Larimer County terminates.

Signature_____

Date _____

Personal Representatives Section:

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

_____
_____