AUTHORIZATION FOR RELEASE OF DISEASE INVESTIGATION RECORDS

Patient Name:____

Date of Birth:____

Parent or Guardian (if applicable)________________________________

Address:____

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Home Phone:____________________ Cell Phone:__________________

I authorize the Tri-County Health Department ("TCHD"), 6162 South Willow Drive, Suite 100, Greenwood Village, Colorado 80111, to provide me with any and all medical records, test results, test analysis, and all other information and interpretations pertaining to myself and/or my child held by TCHD relating to a disease control investigation of _________________ conducted by TCHD that occurred in ____________. I understand that any information not directly pertaining to myself and/or my child is confidential, and may not be disclosed by TCHD pursuant to C.R.S. § 25-1-122.

I also authorize TCHD to release all of the above described information, including my identity, medical records, test results, test analysis and all other information and interpretation relating to me and/or my child held by the TCHD to the following individual, agency, law firm or care provider:

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I understand that my signature on this form is strictly voluntary, and I can refuse to sign this authorization, except as otherwise provided by law. Treatment, payment, or enrollment in a health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure, and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

I understand this authorization will expire, without my express revocation, one (1) year from the date of signing, or if I am a minor, on the date I become an adult according to Colorado law. I understand that I may revoke this authorization at any time in writing, however, the revocation will not apply to records and information that have already been provided under this authorization

prior to TCHD receiving the revocation. To revoke this authorization, I will send a written request to TCHD. I understand that I have a right to a copy of this authorization.

I accept full responsibility for any copying and mailing charges, pursuant to the rates set forth by Colorado law, if applicable, for the preparation of the foregoing copies.

PHOTO COPIES OF THIS AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

____________________________ ______________________________________
Patient Name Date of Birth

_________________________________ _____________________________________
Signature of Patient or Patient's Parent Or Guardian or other authorized person
Date

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Relationship of other authorized person