



BOULDER COUNTY PUBLIC HEALTH

Authorization for Release of Health Information from the Immunization Program

Name: _____

Date of Birth: _____

I authorize Boulder County Public Health (BCPH) Immunization Program to release information about me as designated below to my health care providers, hospitals, insurance company, BCPH Community Infant Program, BCPH GENESIS Program, BCPH WIC Program, BCPH Nurse Family Partnership, or other – (please specify the facility or program that will receive the information):

1. Description of information that may be used/disclosed (**initial** each item to be released):
 Complete immunization records
 Other: _____

2. I specifically authorize the release of information regarding the following condition(s) (**initial** each item to be released):
 Drug abuse
 Alcohol abuse
 Psychological or psychiatric conditions, excluding psychotherapy notes
 HIV/AIDS

I understand that if I have authorized the release of drug and/or alcohol information, federal law (42 CFR, Part 2) protects confidentiality of this information. I understand that if I have authorized the release of HIV/AIDS status, this information is protected from unauthorized disclosure as provided by C.R.S. 1-4-412. The federal rules prohibit the person or entity to whom this information is released from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

3. The information will be used/disclosed for the following purpose(s):
 Assessment
 Care coordination services
 Service Planning
 Referrals
 Other: _____

4. I understand this release is limited to only the above-named persons and entities and does not authorize release of said records, documents, and information to any other persons. However, under federal law, if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. This authorization expires **seven working days** from the date below.

7. I understand that no authorization to release information is needed for BCPH to provide demographic information for statistical purposes to Colorado Department of Public Health & Environment which may help to improve future services or to report certain information regarding positive test results of specific sexually transmitted diseases, and neglect or sexual/physical abuse of minors.

USE OF COPIES: A copy of this form, which shows my signature, may be used with the same effectiveness as an original.

Signature of Patient or Authorized Representative _____
Date

Name of Authorized Representative (if applicable) _____
Relationship to Patient/Description
of Authority

**A COPY OF THIS SIGNED FORM WILL BE PROVIDED TO YOU
AND THE ORIGINAL WILL BE KEPT IN OUR FILES.**