



University of Colorado

Boulder | Colorado Springs | Denver | Anschutz Medical Campus

EMPLOYEE SERVICES

HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name _____ Employee ID _____

I hereby authorize _____ to use or disclose my
(Discloser)

protected health information related to _____
(Type of Information)

to _____ for the following purpose:
(Recipient)

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that I can revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization.
- I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Date

Signature of Individual or Representative

Authority or Relationship to Individual, if Representative

EXPIRATION DATE: This authorization will expire on _____
If no date or event is stated, the expiration date will be one year from the date of this authorization.

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.

Employee Services

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