HIPAA FORM #1

Client Authorization for the Release or Disclosure of Protected Health Information (PHI)

This form must be completed by the person whose protected health information (PHI) is going to be released and/or disclosed ("client") OR by the parent or guardian if the client is a minor.

Today's Date:_____

Name of Client:_____ **Birthdate:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Home Phone:**_____

Mobile Phone:_____ **Email:**_____

BCPH Program that Provided Services to the Client:

☐ BCPH GENESIS ☐ BCPH GENESISTER ☐ BCPH Nurse-Family Partnership (NFP)
☐ BCPH Immunization Program ☐ BCPH Addiction Recovery Centers (ARC)

I hereby authorize Boulder County Public Health (BCPH) to release (i.e. share) or disclose (i.e. reveal) my protected health information (PHI), as detailed in this consent form. I also understand that I may REVOKE this consent at ANY time by providing notice to BCPH.

1. BCPH can share my PHI with the following persons or agencies (select all that apply):

   ☐ My primary care provider (i.e. doctor) (NAME):_____
   ☐ BCPH GENESIS ☐ BCPH GENESISTER ☐ Immunization Program ☐ BCPH Nurse-Family Partnership (NFP)
   ☐ BCPH Women, Infants, and Children (WIC) Program ☐ BCPH Children with Special Needs (CSN) Program
   ☐ Mental Health Partners (MHP) ☐ Boulder County Housing & Human Services (HHS)
   ☐ OTHERS: Please include their names AND either their business names or the nature of their personal relationship (PR) with you as the client (use additional paper, if necessary):

   Name:_____ Business Name or PR:_____

   Name:_____ Business Name or PR:_____

   Name:_____ Business Name or PR:_____

2. Check the PHI below that you're authorizing BCPH to release or disclose to those listed above (select all that apply):

   ☐ Medical history ☐ Evaluation reports ☐ Growth charts
   ☐ Hearing reports ☐ Immunizations or prescriptions ☐ Laboratory reports
   ☐ Current treatment plan ☐ Hospital records ☐ Entire medical record
   ☐ Medical billing or claims information ☐ Case management information
   ☐ OTHER (specify below which records BCPH can release). **NOTE:** If for PSYCHOTHERAPY, MENTAL HEALTH, DRUG/ALCOHOL, and/or HIV/AIDS notes, records, or information, you must ALSO submit HIPAA Form #1-A.

   _____

   _____

3. **Purpose of Release/Disclosure:** My PHI can be shared and used for the following purpose(s):

   ☐ Coordination of my patient care ***OR***
   ☐ Other (please describe):_____

   _____

   _____

4. **Effective Dates of this Consent:** ☐ Continue indefinitely until I revoke this form

   ☐ Only from_____ to_____

5. **Methods for Releasing PHI:** BCPH can share my PHI using the following means (check all that apply):

☐ In person ☐ Telephone ☐ Encrypted Email ☐ Encrypted Fax ☐ U.S. Mail

☐ Friends or relatives (list names):_____

MY AGREEMENTS and APPROVAL

By signing below, I hereby acknowledge that I understand and agree to the following:

A. EXPIRATION OR REVOCATION OF AUTHORIZATION

- ✓ This form will be valid and in effect until either I: 1) revoke it; or 2) the dates listed under #4 above are expired.
- ✓ If I wish to revoke this form, I must complete and return BCPH HIPAA Form #3, *Request from Client to Revoke Authorization to Release or Disclose Protected Health Information (PHI)*, which I can request from any BCPH HIPAA program or BCPH's HIPAA Privacy Official (contact information listed below), **OR** I can contact the HIPAA Privacy Official (below) and verbally request revocation of my authorization:

  Boulder County Public Health
  ATTN: HIPAA Privacy Official
  3450 Broadway, Boulder, CO 80304
  Phone: 303-441-1141 FAX: 303-441-1452

B. AUTHORIZATIONS

- ✓ Your right to this access of records does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal, or administrative action or proceeding, or to information that was received by BCPH in confidence from someone other than another health care provider.
- ✓ I understand that my ability to obtain treatment from BCPH, my eligibility for benefits, etc. will not depend on whether or not I sign this authorization.
- ✓ I understand that I have the right to inspect and obtain a copy of any information that is disclosed to BCPH as a result of this authorization.

C. INSPECTIONS

- ✓ I understand that a BCPH employee will be present if I request an inspection of my PHI.
- ✓ I understand that I won't be allowed to make any marks on or alter my PHI in any way.
- ✓ I understand that I must request a time/date to inspect my records (below), and that I will need to sign/date my records to document that I conducted an inspection.

  Requested Inspection Date:_____Time:_____a.m. / p.m. (circle one)

D. COPY CHARGES

- ✓ I understand and agree that BCPH may charge me up to $0.25/ page for any copies requested, as well as postage fees. If so, I would like BCPH to first call me with an estimate at:_____

E. PROTECTIONS

- ✓ Except for drug and alcohol records that are protected by 42 CFR Part 2, I understand that if I authorize the release/disclosure of my PHI to others, there's a possibility that my PHI could be disclosed to others and would no longer be protected.

Client Signature:_____**Date:**_____

PRINTED CLIENT NAME:_____

If you are NOT the client, please complete the following (PLEASE PRINT):

What is your relationship to the client?

☐ Parent or guardian of the client, who is a minor

☐ Guardian or conservator of the client, who is incompetent

☐ Beneficiary or personal representative of the client, who is deceased

☐ Other – please specify:_____

Your Name:	Date of Birth:
Address:	
City/State/Zip:	E-Mail:
Daytime Phone:	Evening Phone:

Client Representative Signature:_____**Date:**_____

Instructions for submitting this form:

Please complete and return this form to the Boulder County Public Health HIPAA program from which you're making this request, OR you can submit the form to BCPH's HIPAA Privacy Official at the following address:

Boulder County Public Health
ATTN: HIPAA Privacy Official
3450 Broadway
Boulder, CO 80304
Phone: 303-441-1141
FAX: 303-441-1452

BCPH Review Section (for office use only):

☐ The request is for psychotherapy, mental health, drug/alcohol, and/or HIV/AIDS information.
As such, HIPAA Form #1A is ALSO attached: DATE:_____

☐ Request **RECEIVED** by BCPH from client/personal representative (PR): DATE:_____

- ☐ Client/PR notified that form was received (w/in 10 days): DATE:_____
- ☐ **INSPECTION REQUEST:** Time/date that request was submitted: TIME:_____ DATE:_____

☐ Request **APPROVED** by BCPH: DATE:_____

- ☐ Approval decision (Form #1-B; copy attached) mailed to client/PR DATE:_____
- ☐ Requested payment (if any) of $:_____ received on: DATE:_____
- ☐ Records provided to client/PR by BCPH on: DATE:_____

Method of Delivery: _____U.S. Mail to Address Requested _____ENCRYPTED Fax to:_____
_____ENCRYPTED Email to:_____
_____Physical Inspection Location:_____
Time:_____a.m. / p.m. (circle one) Date: _____

☐ Request **DENIED** by BCPH: DATE:_____

- ☐ Request reviewed and denied by:_____ DATE:_____
- ☐ Reason for denial:_____
- ☐ Denial decision (Form #1-B; copy attached) mailed to client/representative: DATE:_____

☐ Request received from client for reconsideration of denial decision (Form #1-C; attached): DATE:_____

- ☐ Review of denial decision conducted by:_____ DATE:_____

Outcome of second review:

- ☐ Original denial decision upheld
- ☐ Original denial decision overturned; original request APPROVED by BCPH
- ☐ Reason original denial decision was overturned:_____

- ☐ Second review decision (Form #1-D; attached) mailed to client/representative: DATE:_____

COMMENTS:

BCPH Program Signature:_____ Date:_____

BCPH HIPAA Privacy Official Signature:_____ Date:_____