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| STATE OF COLORADO |  |
| OFFICE OF ADMINISTRATIVE COURTS |
| 1525 Sherman Street, Denver, Colorado 80203 |
|  |
| Appellant, |
| vs. | 🟂 **COURT USE ONLY** 🟂 |
|  | **CASE NUMBER:** |
|  |  |
|  |
| Appellee. |
|  |  |
| NON-ATTORNEY AUTHORIZATIONFor the Use and Disclosure of Protected Health Information during the Appeal Process |

**\*\*\* This form must be completed if someone will be assisting you in the appeal process \*\*\***

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| The Health Insurance Portability and Accountability Act of 1996 states that we cannot share your protected health information without your permission, except in certain situations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.The Colorado Department of Health Care Policy and Financing may not condition treatment, payment, enrollment or eligibility for benefits on whether you execute this authorization.You may request a copy of this authorization and may revoke/cancel your authorization at any time by notifying the Office of Administrative Courts in writing at the above address. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect. |

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| I,  |  | authorize the |
|  | (Appellant) |  |
| Colorado Department of Health Care Policy and Financing (HCPF), Office of Appeals, as well as the Office of Administrative Courts (OAC), to share my protected health information and other confidential information gathered by the Department to determine my eligibility for services or enrollment in a Colorado Medical Assistance Program. |
| **My Information may be shared with the following person(s) and/or entity:** |
|  |
| (the OAC will only share information about your case with the person(s) listed above) |
| My information may only be shared, disclosed, or used to further and assist in my appeal. **This Authorization will expire at the conclusion of the appeal process.** |
|  |
|  | I will have a non-attorney represent me at hearing and authorize him/her to receive copies of notices, orders and any other documents pertaining to this case. |
| First Name |  | MI |  | Last Name |  | Suffix |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone  |  |  |
| E-mail |  | Relationship |  |  |
| **Appellant’s Signature:** |  | Date: |  |
|  | (Parent/Legal guardian may sign on behalf of minor child) |
| Appellant’s Date of birth: |  | Medicaid ID # |  |
| *\*\*Legal documentation* ***must be*** *included to show authority to sign on behalf of appellant. This may include, but is not limited to Letters of Guardianship or General Powers of Attorney. A Medical Power of Attorney is* ***NOT*** *sufficient to show authority to act as a non-attorney at hearing without the Appellant’s signature above.\*\** |
| I agree to act as the non-attorney representative for the appellant in the above captioned case. I will receive notices, orders and other documents pertaining to this case. |
| **Representative’s Signature:** |  | Date: |  |
|  |  |  | **Rev 3/17** |