Peer Assistance Services
Since 1984

Authorization for Use or Disclosure of Protected Health Information

Pursuant to 45 CFR §164.508 and the Health Insurance Portability and Accountability Act, I,

_____
(first and last name) *(PAS ID)* *(DOB)*

hereby authorize _____ the "disclosing Entity"
(Name of Person or Organization)

and/or his/her administrative and clinical staff to use or disclose the protected health information ("PHI") described below to the persons and for the purposes set forth below:

1. The PHI which I authorize to be used or disclosed are:

_____

_____

_____

2. The entity to receive the PHI identified above is: PEER ASSISTANCE SERVICES, INC., 2170 Parker Road, Suite 229, Denver, CO 80231

3. My PHI may be used or disclosed for the following purposes: ANY

4. This authorization shall be in force and effect until either the following date or event: the later of (a) one year from the date of this agreement; or (b) , at which time this authorization to use or disclose PHI shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written revocation to the Privacy Officer at the Disclosing Entity. I understand that a revocation will not be effective to the extent that the Disclosing Entity has already used or disclosed the PHI described above in reliance on this authorization. I also understand that a revocation will not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

7. I understand that the Disclosing Entity will not condition my treatment on whether I authorize the requested use or disclosure of PHI, except (1) if my treatment is related to research and the use or disclosure is for such research, or (2) my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party, and the use or disclosure is for that third party.

8. By my signature below, I acknowledge that I have received a copy of this authorization to use or disclose PHI.

_____
Signature of Patient or Personal Representative *Date*

_____
Authority of Personal Representative to sign

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