COLORADO
Department of Corrections

AR Form 950-02A1 (04/14/2021)

Authorization for Use and Disclosure of Health Information

Offender Name		DOB	DOC#
I authorize the Colorado Department of Corrections to disclose to:			
Name		Phone Number	Company
Address		City / State / ZIP	
and/or I authorize (other facility)	to disclose to the DOC facility:		
Address		Phone	Requested by:
	Urgent request for offender care fax to:		
	Routine request for offender care mail to address above		
I authorize the following information to be released and/or disclosed:		Date of service:	
	Medical		
	Other:		

The purpose of this disclosure is to be used for: _____Continuity of Care _____Legal Purposes ____At the request of the individual _____Other: _____

I understand that:

- The information disclosed may contain testing information or treatment information relating to Sexually Transmitted Diseases; HIV/AIDS virus.
- Once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulations.
- This authorization will be valid for the duration of the incarceration plus 90 days after release.
- This authorization expires upon the individual's death.
- This form may be revoked at any time providing that the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the health records custodian.
- DOC may not use as a condition of treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization except as allowed by law.
- I am entitled to a copy of this signed authorization.
- By signing I acknowledge I have_____ inspected or _____have received a copy of requested records.

Printed Offender Name	Offender Signature	Date
Printed Name of Person Authorized to Sign for Offender	Signature of Person Authorized to Sign for the Offender	Date
DOC Employee Signature		Date