Health District
ADVANCE CARE PLANNING TEAM

Larimer Advance Care Planning Team
Authorization to Release Information

Name of Consenting Person: _____ Date of Birth: _____

Phone Number: _____

Name of Referring Agency: Health District of Northern Larimer County

Contact Name: _Any Member of the Larimer ACP Team _____ Phone: (970) 482-1909

Address, City, State, Zip: 120 Bristlecone Drive, Fort Collins, Colorado 80524 (Administration Office)

This release is a voluntary consent to allow the Health District of Northern Larimer County to enter into ongoing discussion(s) with any of the departments/agencies listed below. The purpose of the discussion(s) is to allow the providing and/or sharing of information necessary to provide ongoing services for the benefit of the undersigned. Shared information, including my protected health information, will be provided only on a need-to-know basis and only from the department(s) specified below. The shared information may be VERBAL and/or WRITTEN.

The following are the county departments and other agencies that have been identified to share information about this individual. By initialing next to the agency listed, I authorize that information may be released and requested on a need-to-know basis from the departments and agencies indicated below:

_____ UCHealth Medical Records Department

_____ Banner Health Medical Records Department

_____ Organization: _____ Phone: _____
Address, City, State, Zip: _____

_____ Organization: _____ Phone: _____
Address, City, State, Zip: _____

I understand that the information obtained will be shared and used for assessing, planning and facilitating the delivery of services for my benefit. My signature below indicates that I consent to any or ALL department/agencies indicated above discussing records and summaries of information. I further understand that this voluntary consent provides for ongoing discussions and the sharing of information necessary to provide continued services.

I hereby release and hold harmless all of the departments/agencies designated herein from any and all liability and claims of any kind related to this release and the sharing of information as described in the foregoing, provided by any/all of the departments and or agencies. I further acknowledge receiving a copy of this authorization to release.

This release will expire one year from the date of signing unless revoked earlier by the participant.

_____ _____
Client/Parent Legal Guardian/Power of Attorney Signature Date

_____ _____
Agency Representative Signature Date

In the event the participant is under the age of 18 years and not emancipated, the participant's parent or legal guardian must sign this release. Verification of the parent or guardian status must be obtained prior to signing.

A properly completed photocopy of this release is as valid as the original

Revoke Authorization:

By signing below, I certify that I am revoking the above authorization as of this date

_____ _____
Client/Parent Legal Guardian/Power of Attorney Signature Date

Form Created October 28, 2015