AUTHORIZATION TO EXCHANGE CONSUMER INFORMATION

I authorize the Center for People with Disabilities (CPWD) to share information and to exchange individual information that is specific to me. This permission applies to CPWD staff and agents and may include protected health information, photocopies, fax copies, notes, audio, video, electronic, and verbal communication. Information disclosed under this authorization will no longer be protected to the CPWD privacy policy.

Specifically, I authorize this exchange of information with:

_____

_____

_____

I certify that this authorization to exchange and release information is made voluntarily. I understand that I may revoke this authorization by giving written notice to CPWD and that any information requested prior to my revoking this authorization shall not be a breach of my right to confidentiality.

Furthermore, I release CPWD from liabilities that may result from furnishing this information.

Without my written revocation, this Authorization will expire:_____
(date xx/xx/xxxx)

Name: _____ Date of Birth _____
(please print)

Signature: _____ Date: _____

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Boulder, CO 80301
Ph: (303) 442-8662
Fx: (303) 442-0502

Longmont
615 North Main Street
Longmont, CO 80501
Ph: (303) 772-3250
Fx: (303) 772-5125

Broomfield
26 Garden Center, Suite 1
Broomfield, CO 80020
Ph: (720) 308-7705
Fx: (303) 469-3546

North Metro
10317 Washington Street
Thornton, CO 80229
Ph: (303) 790-1390
Fx: (303) 792-0317

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