COLORADO
Department of Health Care Policy & Financing

ACCESS TO PROTECTED HEALTH INFORMATION

Return Completed Form by fax or mail to:
Privacy Office
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Denver, CO 80203 Fax: (303) 866-4411

***** Please include copy of your Medicaid ID card and Driver's License, or equivalent *****

The Health Insurance Portability and Accountability Act of 1996 requires that we protect the privacy of your protected health information. You have a right to request a copy of your protected health information contained in a designated record set and held by the Department of Health Care Policy and Financing. This request must be made in writing and may be denied by the Department under certain circumstances. You cannot have access to any psychotherapy notes taken by your mental health therapist or information prepared for use in a civil, criminal, or administrative legal action. The Department will act on your request within 30 days (60 days if the information is off site), unless we provide you with notification in writing that a 30-day extension is needed. If the Department denies your request, we must provide you with a written explanation of the basis for that denial. In some situations, you have a right to request a review of our denial. See the Department's Privacy Policy and Procedures on Right to Access Protected Health Information, pursuant to 45 C.F.R. 164.524.

This form is to be used when clients or their Personal Representative request access a copy of their Designated Record Set. HCPF's Designated Record Set consists of claims information including first dates of service, dates of payment, name of billing providers and ID, provider type, and payment amount. If you wish to receive copies of your medical records (such as charts, doctor's notes, etc.), you need to contact the medical facility where you received treatment, as the Department does not keep these records. DO NOT use this form if your request for claims is related to a trust, a recovery of benefits, or a Medicaid lien involving an injury or accident. Instead, please contact the appropriate unit within the Third Party Liability and Recoveries section of the Department by visiting https://hcpf.colorado.gov/coordination-benefits.

Member Name: _____ Date of Birth: _____

Medicaid ID number:_____Phone Number: _____

Address: _____

City, State, Zip: _____

Information Requested: _____

How would you like to receive your records?

1) **Requested format**: ☐ Electronically ☐ Paper
2) **Delivery method:**

☐ Email Address:_____Attn to:_____

☐ Mail: Attn to:_____
Name, Address, City, State, ZIP

Signature:_____Date:_____
Parent or Legal Guardian may sign on behalf of minor child.
Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult. Documentation is required.

If signing on behalf of another person, please provide the information below:

Name of Designated Personal Representative: _____

Relationship to client: _____