



**Tuberculosis Program
Authorization for Release of Information**

[This authorization reflects the requirements of 45 CFR § 164.508 (August 14, 2002).]

I _____ authorize the staff of the Tuberculosis Program at
patient name

the Colorado Department of Public Health and Environment to release my Tuberculosis
screening, diagnostic and treatment information to _____

agency/organization name

agency/organization mailing address

I understand that the information will be used per my request. I understand that signing
this authorization is not a condition of receiving services. I understand that I have the
right to revoke this authorization at any time by notifying the Tuberculosis Program in
writing. I understand that the revocation is only effective after it is received and logged.

I understand that any sharing of information prior to revoking this authorization will not
be affected by a revocation. This authorization expires: _____. I
expiration date or event

understand that once released, my information may be disclosed by _____
agency/organization
and may no longer be protected.

Signed: _____ Date: _____
Patient name

if personal representative, explain relationship to the patient

Witness: _____
(MUST BE NOTARIZED)

copy to patient/personal representative