



Crime Victim Compensation Board

Twenty-Third Judicial District of Colorado

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PROUDLY SERVING DOUGLAS, LINCOLN AND ELBERT COUNTIES

Authorization for Release of Information

The 23rd Judicial District Crime Victim Compensation (CVC) Program operates pursuant to C.R.S. 24-4.1-101 and is intended to provide financial assistance to victims of crime. As part of the application process, the CVC program often requires access to sensitive medical, mental health, employment and/or other personal information.

In an effort to preserve the privacy of victims and maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA), any materials received by the CVC Board are kept confidential pursuant to C.R.S. 24-4.1-107.5. Materials received by the CVC Board are intended only for the purposes of determining eligibility for CVC funds and verifying crime-related expenses.

VICTIM INFORMATION

Victim Name: _____

Date of Birth: _____

Social Security Number (Last 4 digits only): _____

Address: _____

AUTHORIZED REPRESENTATIVE

If the victim is unable to authorize release, a designated representative may provide authorization on the victim's behalf.

Representative Name: _____

Relationship to Victim: _____

RECIPIENT OF INFORMATION

Crime Victim Compensation Board
 23rd Judicial District
 4000 Justice Way, Ste 2525A, Castle Rock, CO 80109
 Fax: (720) 733 - 4672
 Email: DAVictimComp@coda23.gov

I, _____, hereby authorize Crime Victim Compensation program staff to communicate directly with my medical providers, including any creditor associated with my crime-related medical debt, my employer(s), and/or my civil attorney. I further authorize Crime Victim Compensation program staff to request and receive the following information:

- All crime-related medical records
- Medical billing statements and account status information only
- Employment information
- Information from my attorney related to a civil suit or insurance settlement

By signing this form, I understand the above authorization is valid for one year from the date of signature. I understand I have the right to revoke authorization at any time by providing written notice to the party authorized to release information. I further understand the information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Printed Name of Victim or Victim Representative

Signature of Victim or Victim Representative

Date

**MAIL COMPLETED FORM TO:
OFFICE OF THE DISTRICT ATTORNEY
C/O CRIME VICTIM COMPENSATION
4000 JUSTICE WAY, STE 2525A, CASTLE ROCK, CO 80109**