ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION TO RELEASE RECORDS

Member's Name *(Last, First, M.I.)*: ______________________________

____

Other former legal names used *(Last, First, M.I.)*: ______________________________

Date of Birth: ____________________ AHCCCS ID: ______________________________

Support Coordinator Name: ______________________________

Please note: If the information or both pages within this authorization are not completed and submitted your request may be delayed.

I, ______________________________ authorize **The Arizona Division of Developmental Disabilities (DDD)** to disclose my Personal Health Records as selected on page 2 of this form. I request the records be sent to the individual listed below and only in the manner approved by me.

Name of the authorized person to release the records to: ______________________________

Email Address: ______________________________ Phone Number: ____________________

Address *(No., Street)*: ______________________________

City: ______________________________ State: ____________________ ZIP Code: ____________

PURPOSE FOR DISCLOSURE *(Check applicable categories)*:

I understand the following:

1. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
2. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.
3. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law.

Initials: ___________

This authorization shall be in force and effect one year from the date of execution at which time this authorization expires. If the request involves a minor the authorization will expire upon the 18th birthday.

Legally Authorized Representative Signature: ______________________________ Date: ____________

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local

AUTHORIZATION TO RELEASE RECORDS

Personal Health Records Requested (The document types and dates must be specific for the records you are requesting. A written request for "all records" without specificity of record type and date may cause delays).

Behavioral Health: Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

Billing: Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

DDD Eligibility: Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

Progress Notes: Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

Service Plan: Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

Speech, Physical, Occupational Therapy: Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

Other *(specify)*: ________________________________ Start Date __________________ to End Date __________________
(mm/dd/yyyy) *(mm/dd/yyyy)*

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired, Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and substance use disorder treatment. My initials authorize such release as indicated. I specifically authorize the release of the following information:

Substance use disorder treatment records (initial) ___________

HIV test results (initial) ___________

Mental Health treatment information (initial) ___________

Note: *Psychotherapy notes, as defined in the federal regulations implementing HIPAA must be requested from the treating provider if DDD does not have them as part of the record.*

To request your records, you may write, fax, or email your request to DDD. Submitting your request via email allows DDD to process your request more efficiently.

Email: DDDRecordsrequest@azdes.gov or in writing to:
Attn: Records Management Unit
Division of Developmental Disabilities
Mail - 1002 S. 63rd Ave. Unit 102/2HE6
Phoenix, AZ 85043
Phone: (602) 774-5221
Fax: (602) 807-5001

I request records be sent via email (initial) ___________

US Mail (initial) ___________

Other *(specify)* ____

____

(initial) ___________