ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION FOR RELEASE OF INFORMATION

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FAX: _____

ATTN: _____

Name of Person to Receive Documents

(Use the DES-166 envelope)

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_____

Applicant/Patient's Name (Last, First, M.I.)
Birthdate _____
Address *(No., Street,/PO Box No.)*
City/State/ZIP Code _____

INFORMATION REQUESTED

☐ Developmental Evaluation ☐ Behavioral Health Records ☐ Latest IPP/IEP ☐ Psycho Educational Evaluation

☐ Medical Documentation or Developmental Disability ☐ Social History ☐ Medical Records

☐ Vocational Evaluation ☐ Physical/Occupational/Speech Therapy Evaluation

☐ Other *(Specify)* _____

Copying fees will not be reimbursed by the Division • The information sought is the minimum amount of information the Division needs for the purpose stated below.

Comments: _____

AUTHORIZATION

I authorize the above named company, school, agency, health care provider or individual to disclose to the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) the above indicated health, medical information, and/or other records requested. The purpose of this release is to assist in determining eligibility for services with the DES/DDD, or if eligible, to assist in providing treatment services. This authorization shall expire one year from the date below.

I understand that I can revoke this authorization at any time by written notice to the provider of records, except to the extent that the disclosure authorized has been acted upon prior to receipt of any written revocation.

I understand that I do not have to sign this authorization. If I do not sign it, I understand that the Division may not be able to determine eligibility for services. I understand that a health plan may not condition treatment, payment, or enrollment in a health plan on my signing this authorization.

I understand that once the records and information authorized herein are disclosed to entities or persons outside of DDD, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, DES/DDD service providers generally are bound by contract and law to maintain the confidentiality of the health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

I understand that I have a right to have a copy of this form.

Applicant/Personal Representative's Name *(Print Name)* _____

Applicant/Personal Representative's Signature _____ Date _____

My authority as a personal representative to make health care decisions for this person is:

☐ Parent of a Minor ☐ Guardian ☐ Court Appointed Conservator ☐ Health Care POA

A FACSIMILE OR PHOTOCOPY OF THIS AUTHORIZATION IS CONSIDERED TO BE AS AUTHENTIC AS THE ORIGINAL

Routing: ORIGINAL – Keeper of records; **COPY** – Case file; **COPY** – Applicant/Personal Representative

See reverse for EOE/ADA/LEP/GINA disclosures

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 602-542-0419; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local.