

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act of 1996 - 45 C.F.R. § 164.508

Name of person/organization disclosing health information: _____

Name of individual/client whose specific health information is being disclosed: _____

Describe the protected health information to be disclosed in sufficient detail to enable both the individual signing this authorization and DES to clearly identify the health information authorized for disclosure:

Name of person/organization receiving the health information: _____

Describe the specific purpose of this release. The statement *"at the request of the individual"* is sufficient when an individual initiates the authorization:

This authorization's expiration date, event, or condition: _____

If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.

I understand that I may revoke this authorization at any time by written notice to the person/organization named above that is disclosing my health information, except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation.

I understand that I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

I understand that once the records and information authorized herein are disclosed, 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, health care service providers generally are bound by contract and law to maintain the confidentiality of the health information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.

I understand that I may have a copy of this signed authorization if I request it.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act of 1996 - 45 C.F.R. § 164.508

Authorizations:

Print or type Full Name of Individual/Client or Personal Representative

Signature of Individual/Client or Personal Representative

Date Signed

Description of personal representative's authority *(If applicable)*:

This authorization was revoked/withdrawn in writing on: _____

Signature of staff

NOTE: A Facsimile or Photocopy of this Authorization is Considered To be as Authentic as the Original

[This form is not endorsed or approved by any official organization or entity. It is offered as one basic example of a HIPAA compliant form. It does not authorize the use or disclosure of substance abuse information or HIV/AIDS related information. The user of this form assumes all responsibility and liability for its use.]

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.