ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Rehabilitation Services Administration

AUTHORIZATION FOR RELEASE OF RSA RECORDS

(Including HIPAA Covered Records)

I, the undersigned individual or legal representative, hereby authorize the Rehabilitation Services Administration (RSA) to use or disclose confidential client information regarding:

Name ______________________________

Also Known As (AKA) / Maiden Name

____

Address (No., Street)

____

City ______________________________

State ____________ **ZIP Code** ______________________

Date of Birth ______________

Authorization Expiration Date ____________________

Phone Number ______________________________

See page 6 for EOE/ADA/LEP/GINA disclosures

The information may be disclosed to and used by the following:

Name: ______________________________

Attention: ______________________________

Address (No., Street)

____

City ______________________________

State ____________ **ZIP Code** ______________________

Phone Number ______________________________

Fax Number ______________________________

Requested Method of Delivery:

Mail **Verbal** **Pick-up** **Email** **Fax**

Email Address ______________________________

Relationship to RSA Client ______________________

The date(s) of service and the type(s) of information to be used or disclosed are as follows:

RSA Case Notes

Medical Records

Functional Capacity Evaluation

Vocational Evaluation

Vendor Progress Notes

Psychological / Neuropsychological Evaluation

Other

Other

All RSA Records

The purpose of this disclosure or use is:

- **Controlling federal and state statutes limit RSA release of confidential client information. I understand by signing this release I authorize release of my confidential information to the named recipient.**
- **RSA may be in possession of secondary source information that is prohibited from re-release. This information may be requested from the original source through the client.**
- **Reports and evaluations generated by RSA are intended for the sole purpose of planning and administering an individualized rehabilitation program.**
- **RSA will not accept liability for the use of this information in any other manner than intended and authorized by the client.**

- **Confidential client information may not be used by the recipient for purposes not stated in this authorization.**
- **The recipient may not release confidential client information to others.**
- **If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.**
- **I understand that except to the extent that the disclosure authorized has been acted upon prior to the receipt of any revocation I may revoke this authorization at any time by written notice to RSA.**
- **I understand that I may have a copy of this signed authorization if I request it.**
- **The parent or legal guardian must sign this authorization if the RSA applicant/client is a minor (under age 18) or has a legal guardian.**

RSA Applicant/Client's Signature

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Date ____________________

Parent or Legal Representative's Signature

____

Date ____________________

If signed by the Legal Representative, indicate your relationship to the individual and provide appropriate documentation to verify your authority.

Parent **Guardian** **Power of Attorney**

Other: ______________________________

A copy of this completed, signed and dated form must be given to the Legal Representative on behalf of the individual.

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 your local office; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local.