ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Rehabilitation Services Administration

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO RSA

I, the undersigned Rehabilitation Services Administration (RSA) applicant/client or legal representative, hereby authorize:

Person / Organization

_____

Address (No., Street)

_____

City _____

State _____ **ZIP Code** _____

Phone Number _____

FAX Number _____

To use or disclose health information including, if applicable, information relating to the diagnosis and treatment of mental illness, drug and/or alcohol abuse and HIV related information regarding:

See page 7 for EOE/ADA/LEP/GINA disclosures

Name _____

Also Known As (AKA)

_____

Address (No., Street)

_____

City _____

State _____ **ZIP Code** _____

Date of Birth _____

Authorization Expiration Date _____

Client ID Number _____

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

ARIZONA DEPARTMENT OF ECONOMIC SECURITY / REHABILITATION SERVICES ADMINISTRATION

Attention:

_____

Address (No., Street)

_____

City _____

State _____ **ZIP Code** _____

Phone Number _____

Fax Number _____

Requested Method of Delivery:

☐ **Mail** ☐ **Verbal** ☐ **Pick-up** ☐ **Review** ☐ **Fax**

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

☐ **Medical History**

☐ **Hospital Summary(s)**

☐ **Outpatient Treatment Notes**

☐ **Laboratory Report**

☐ **Progress Notes**

☐ **Psychiatric Evaluation**

☐ **Psychological Evaluation**

☐ **Education Records**

☐ **Other**

The purpose of this disclosure or use is:

☐ **Medical**

☐ **RSA eligibility and service provision**

☐ **At the applicant/client's request**

☐ **Other:** _____

- **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 name 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 revocation.**
- **I understand that I do not have to sign this authorization, and RSA may not condition eligibility and service provision on whether or not I sign this authorization.**
- **I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.**
- **Information received will be used in the administration of an individualized rehabilitation program for the above-name individual. RSA may release this information only as necessary for the administration of an individualized rehabilitation program, unless the provider of this information specifies other conditions for its release.**

- **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

_____

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