ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Rehabilitation Services Administration

AUTHORIZATION/CONSENT FOR DISCLOSURE AND USE OF CONFIDENTIAL INFORMATION BETWEEN DDD AND RSA

(Including Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Covered Records)

I, the undersigned individual or legal representative, hereby authorize the disclosure and use of confidential client information between the Division of Developmental Disabilities (DDD) and the Rehabilitation Services Administration (RSA) regarding:

Name: _____

Also Known As (AKA) / Maiden Name:

_____

Address (No., Street):

_____

City: _____

See page 7 for EOE/ADA disclosures

State: _____ **ZIP Code:** _____

Date of Birth: _____

Authorization Expiration Date: _____

Phone Number: _____

The information may be disclosed to and used by:

☐ **DDD**

Attention:

_____

Address:

_____

Phone: _____ **Fax:** _____

Email: _____

☐ **RSA**

Attention:

_____

Address:

_____

Phone: _____ **Fax:** _____

Email: _____

The purpose of the disclosure and use is:

- ☐ **Medical**
- ☐ **DDD eligibility and service provision**
- ☐ **RSA eligibility and service provision**
- ☐ **Other *(Specify purpose)*:**

_____

Vocational Rehabilitation will not be able to rerelease any secondary source information.

The Type of information to be used or disclosed are as follows:

- ☐ **Case Notes/Status Update**
- ☐ **Medical/Psychological Records (may contain secondary information)**
- ☐ **Individualized Plan for Employment (IPE)**
- ☐ **Individualized Service Plan (ISP)**
- ☐ **Program Eligibility**
- ☐ **Vendor Progress Notes**
- ☐ **Psychological Evaluations (may contain secondary information)**
- ☐ **Vocational Evaluations**

☐ **School Records (may contain secondary information)**

☐ **Behavioral Health Records (may contain secondary information)**

☐ **Guardianship Documents (may contain secondary information)**

☐ **Other (Specify type and date):**

- **Controlling federal and state laws (45 CFR 160, 162 and 164 et seq,) 45 CFR 164.500 et seq, 34 CFR 361.38, A.R.S. § 41-1959, A.R.S. § 36-568.01, AAC R6-4-405) limit RSA and DDD release of confidential information. I understand that by signing this release I authorize the use and disclosure of my confidential information between the RSA and DDD.**
- **Reports and evaluations generated by RSA are intended for the sole purpose of planning and administering an individualize rehabilitation program and the provision of supported employment services.**
- **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.**

- **RSA and DDD 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.**
- **I understand that once any HIPAA covered records and information authorized here are disclosed, they could be re-disclosed by the recipient and may no longer be protected by HIPAA. However, contracted health care and service providers generally are bound by contract and law to maintain the confidentiality of the health information received, especially relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.**
- **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 excelp as provided under state or federal law.**

- **I understand that except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation, I may revoke this authorization/ consent at any time by written notice to RSA and DDD.**
- **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 have a copy of this signed authorization/consent if I request it.**
- **The parent or legal guardian must sign this authorization if the RSA applicant/client/ DDD member is a minor (under the age of 18) or has a legal guardian.**

Applicant/Client 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 facsimile or photocopy of this authorization is considered to be as authentic as the original.