ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Person to Receive Documents

(Use the DES-166 envelope)

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 • 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 the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; 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.