ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Child's Name *(Last, First, M.I.)* _____

AHCCCS ID NO. *(Or other record no.)* _____ Date of Birth _____

I give permission for the following entity to disclose my protected health information:

Medical Profession/Agency _____ *Date of Request* _____

To the following AzEIP Service Providing Agency:

Requesting Program's Name _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Phone NO. _____ Fax NO *(If Faxing)*. _____

I SPECIFICALLY AUTHORIZE THE PROTECTED HEALTH INFORMATION CHECKED BELOW TO BE DISCLOSED TO THE ENTITY LISTED ABOVE:

- ☐ Physicians' Records
- ☐ Newborn Records
- ☐ Labor, Birth & Delivery Records
- ☐ Audiology Records/Reports
- ☐ Psychological Reports
- ☐ Occupational Therapy Reports
- ☐ Speech and Language Reports
- ☐ Physical Therapy Reports
- ☐ Other *(Specify):* _____

I acknowledge that (check one):

- ☐ This disclosure is being made at my request, and I choose not to state the reason for this disclosure; or
- ☐ I specifically authorize the disclosure of protected health information for the following purpose(s):

By placing my initials in front of the following items, I specifically authorize the disclosure of information regarding the following:

____ Genetic Testing ____ Mental Health ____ HIV/AIDS/Other communicable diseases ____ Drug and/or Alcohol Abuse

By signing this **Authorization**, I understand that:

- I may refuse to sign this authorization and my refusal will not affect my eligibility for benefits.
- I may inspect or copy any information to be disclosed under this authorization.
- I may have a copy of this document.
- I may revoke this authorization at any time, by sending written notification of the revocation to:

Name of Service Coordinator _____

Name of Responsible Party _____

Signature of Responsible Party _____

Date of Authorization _____ Date Authorization Expires _____

- A copy of this authorization shall be as valid as the original.

PROVIDER/AGENCY/INDIVIDUAL POSSESSING HEALTH HEALTH INFORMATION:

Received By _____ Date of Receipt _____

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 your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.