ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION VIA UNSECURED EMAIL

INDIVIDUAL'S INFORMATION

Name *(Last, First, M.I.)*: _____

Assist Number: _____ Birth Date: _____ Request Date: _____

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

The Division of Developmental Disabilities ("the Division") is required to encrypt all email communication that contains Protected Health Information (PHI).

Other alternatives to unsecured email include US Mail, telephones, and faxes.

By signing below, I hereby authorize the Division to transmit non-secure email for the following types of protected health information related to the services received through the Division:

- Information related to the scheduling of meetings or other appointments;
- Documents that may contain clinical and confidential information such as Person Centered Service Plans, Assessments, Evaluations, Medications, etc.; and,
- Information related to billing and payment (which may include financial or claims-related information such as insurance plan numbers and code sets.)
- Other documentation included in the designated records set.

I fully understand that third parties may attempt to or actually access, use, and disclose PHI transmitted by the Division via email. I fully understand the risks of transmitting unencrypted emails containing PHI; I am willing to accept those risks.

This authorization's expiration date, event, or condition:

If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.

Print the full name of the member or personal representative: _____

Signature of the member or personal representative: _____ Date Signed: _____

Description of personal representative's authority *(if applicable)*: _____
