

Arizona Department of Economic Security
Division of Developmental Disabilities

**Authorization for Disclosure of
Protected Health Information
Health Insurance Portability and Accountability
Act (HIPAA) Act of 1996 45 C.F.R. 164.508**

Name of Individual/Client whose health information will be shared
(*Last, First, Middle*):

Date of Birth: _____

Describe what this information will be used for and why it is
needed:

I authorize **Arizona Department of Economic Security, Division of Developmental Disabilities (DDD)** to disclose (share) protected health information described above to the individual/agency below.

Individual/Agency requesting or needing information:

Date of Request: _____

By signing this Authorization, I understand that:

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 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 except as provided under state or federal law.

- I may have a copy of this document.
- I may revoke this authorization at any time, by sending written notification of the revocation; except to the extent that the disclosed authorization has been acted upon.
- A copy of this authorization shall be as valid as the original.
- Copy fees will not be reimbursed by the Division.

- This authorization shall expire a year from the date below.

Printed Name of Parent or Legal Guardian:

Signature of Parent or Legal Guardian:

Date of Authorization: _____

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 the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/ TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local