Arizona Department of Economic Security
Division of Developmental Disabilities

Authorization for Release of Information

Individual's Full Name: ____ Date of Birth: ____________
(Last, First, Middle)

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

Medical Professional/Agency/Educational Setting/Other:

____ Date of Request: ____________

To the Division of Developmental Disabilities:

Address *(No., Street)*: ____

City: ____ State: ______ ZIP Code: ____________

Phone Number: ____________________________ Fax Number *(If faxing)*: ____________________________

I allow the protected health information checked below to be shared with the medical professional, agency, educational setting or other listed above:

Physician Records	Newborn Records	Labor, Birth & Delivery Records
Audiology Records/Reports	Psychological Reports	Occupational Therapy Reports
Speech and Language Reports	Physical Therapy Reports	Mental Health Records
Latest 504 Plan or Individual Education Plan and Evaluation Report		Other *(Specify)*: ____________________

This disclosure is being made at my request, and I choose not to state the reason for this disclosure. Information will be used to determine eligibility for the Division of Developmental Disabilities. This authorization shall expire a year from the date below.

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.

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

- I may refuse to sign this authorization; however, I understand that the DDD may not be able to determine eligible for services.
- 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; 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.

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