Arizona Department of Economic Security
Division of Developmental Disabilities

Educational Authorization for Release of Information

DDD Member's Full Name *(Last, First, Middle)*: _____

Date of Birth: _____

I give permission for the following entity to share my protected health information:
Educational Setting or Agency:

1. _____
2. _____
3. _____
4. _____

I allow the protected health information checked below to be shared with the Division of Developmental Disabilities:

- ☐ Individualized Education Plan (IEP)
- ☐ Multidisciplinary Evaluation Team Report (MET)
- ☐ 504 Plan
- ☐ Audiology Records/Reports
- ☐ Psychological / Psychiatric Reports
- ☐ Occupational Therapy Reports
- ☐ Speech and Language Reports
- ☐ Physical Therapy Reports
- ☐ Vocational Rehabilitation
- ☐ ABA Records
- ☐ Documentation of Special Education Accommodations
- ☐ 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.

See page 2 for EOE/ADA disclosures

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: _____

(Next section to be completed by DDD Employee Only)

Date of Request: _____

To the Division of Developmental Disabilities:

Address *(Number, Street)*: _____

City: _____ State: _____ ZIP Code: _____

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

Attention: _____ Email: _____