

## Authorization/Consent for Disclosure and Use of Confidential Information Between DDD and RSA

*(Including Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Covered Records)*

I, the undersigned individual or legal representative, hereby authorize the disclosure and use of confidential client information between the Division of Developmental Disabilities (DDD) and the Rehabilitation Services Administration (RSA) regarding:

Name: \_\_\_\_\_ Also Known As (AKA) / Maiden Name: \_\_\_\_\_

Address (Number, Street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Authorization Expiration Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### The information may be disclosed to and used by RSA and DDD:

#### Division of Developmental Disabilities:

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

#### Rehabilitation Services Administration:

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### The purpose of this disclosure and use includes both DDD and RSA eligibility and service provision.

Other (Specify purpose): \_\_\_\_\_

### The following information to be used or disclosed includes:

*(Check all that apply)*

Case Notes/Progress Notes

Medical/Psychological Records (may contain secondary information)\*

Individualized Plan for Employment (IPE)

Person-Centered Service Plan (PCSP)

Program Eligibility

Vendor Progress Notes

Psychological Evaluations (may contain secondary information)\*

Vocational Evaluations

School Records (may contain secondary information)\*

Behavioral Health Records (may contain secondary information)\*

Guardianship Documents (may contain secondary information)\*

Other (Specify type and date): \_\_\_\_\_

\*Vocational Rehabilitation will not be able to re-release any secondary source information.

- Controlling federal and state laws (45 CFR 160, 162 and 164 et seq,) 45 CFR 164.500 et seq, 34 CFR 361.38, A.R.S. § 41-1959, A.R.S. § 36-568.01, AAC R6-4-405) limit RSA and DDD release of confidential information. I understand that by signing this release I authorize the use and disclosure of my confidential information between the RSA and DDD.
- RSA & DDD shall correspond in writing and/or verbally, with the minimum amount necessary required for service provision.
- Reports and evaluations generated by RSA are intended for the sole purpose of planning and administering an individualize rehabilitation program and the provision of supported employment services.
- RSA may be in possession of secondary source information that is prohibited from re-release. This information may be requested from the original source through the client.
- RSA and DDD will not accept liability for the use of this information in any other manner than intended and authorized by the client.
- Confidential client information may not be used by the recipient for purposes not stated in this authorization.
- The recipient may not release confidential client information to others.
- I understand that once any HIPAA covered records and information authorized here are disclosed, they could be re-disclosed by the recipient and may no longer be protected by HIPAA. However, contracted health care and service providers generally are bound by contract and law to maintain the confidentiality of the health information received, especially relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.
- I understand that 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 excelp as provided under state or federal law.
- I understand that except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation, I may revoke this authorization/consent at any time by written notice to RSA and DDD.
- If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.
- I understand that I may have a copy of this signed authorization/consent if I request it.
- The parent or legal guardian must sign this authorization if the RSA applicant/client/DDD member is a minor (under the age of 18) or has a legal guardian.

Applicant/Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by the Legal Representative, indicate your relationship to the individual and provide appropriate documentation to verify your authority.

**Parent      Guardian      Legal Representative      Other:** \_\_\_\_\_

***A facsimile or photocopy of this authorization is considered to be as authentic as the original***