AUTHORIZATION TO DISCLOSE
PRIVATE HEALTH CARE INFORMATION

✓ (Note: Federal law requires All information identified by a check to be completed before information can be released)

✓ Name of individual served:_____Phone_____

✓ Date of Birth;_____

✓ I authorize_____
(Name and address of individual or organization that may disclose your protected health information. Be sure to provide complete name and address of the individual/agency from whom DEAP should request information)

✓ To use and/or disclose private health care information as described below to:

Name:_____
(Name of person, class of persons, or organization to whom your protected health information may be disclosed)
Address:_____

City:_____State:_____Zip:_____

✓ The type and amount of information to be used or disclosed is as follows (*Please check those that apply):*

- o Social History (therapy progress background information regarding problems/treatments
- o Clinic medical records (lab or x-ray reports, pathology reports, immunization record, treatments, physical exams, referral reports/progress)
- o Hospital medical records
- o Ophthalmology (vision) records
- o Audio logical Evaluation Information and/or reports
- o Physical Therapy Evaluation Information and/or reports
- o Speech/language Information and/or reports
- o Family Treatment plan
- o Health and Developmental History Information and/or reports
- o Occupational Therapy Evaluation Information and/or reports
- o Educational Assessments, Individual Education Plan, Child Study Team Information
- o Individualized Family Service Plan
- o Date(s) of service or period of time_____
- o Doctor_____
- o Type of service provided_____
- o A representative of _____may discuss my protected health information
- o Other_____

---over---

- ✓ I authorize the release of information in my health record which may include information relating to:
  - Sexually transmitted disease
  - Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)
  - Behavioral or mental health services
  - Treatment for alcohol and drug abuse which is protected by virtue of the provisions of Federal Regulations 42 CFR, part 2.

- ✓ This information is needed for the purpose of :
  - At the request of the patient
  - Other_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes providing treatment services in reliance on a valid consent to disclose information to a third party payer. **Until otherwise revoked, this authorization will expire in one year.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules (unless the information is protected by 42 CFR for alcohol/drug abuse records).

_____

- ✓ Signature of individual served or legal representative Date

_____

- ✓ If Signed by Legal Representative, Relationship to individual

_____

- ✓ Witness