DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name:____

Date of Birth:____

1. Person(s) authorized to use, disclose or receive information, include legal guardian, if applicable:

Primary Contact:	**Alternate Contact:**
Name:______________________________ Address:____________________________ __________________________________ Phone:______________________________ Alt Phone:___________________________ Relationship:_________________________	Name:______________________________ Address:____________________________ __________________________________ Phone:______________________________ Alt Phone:___________________________ Relationship:_________________________
Other Contact: Name:______________________________ Address:____________________________ __________________________________ Phone:______________________________ Alt Phone:___________________________ Relationship:_________________________	Other Contact: Name:______________________________ Address:____________________________ __________________________________ Phone:______________________________ Alt Phone:___________________________ Relationship:_________________________

Attach additional sheets if needed.

2. I am authorizing DDD staff to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization

3. I am authorizing the DDD staff to provide the minimum necessary health information to the individuals listed above and/or other individuals who are permitted to visit.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect ability to obtain treatment or payment or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.

7. The authorization expires on _________________ or one year from the date of the individual's/legal guardian's signature.

8. A complete copy of this form will be maintained in the client record.

9. To Legal Guardians: If the individual receiving services is over the age of 18 and you have indicated that you are the Legal Guardian for this individual, you must attach a copy of Appointment of Guardianship to this form.

Signature (or mark) of
Individual or Legal Guardian:____

Date of Signature:____

Name of Legal Guardian* (if applicable):_____________________________________
*Copy of Valid Appointment of Guardianship must be attached.

If Mark is provided in place of signature, the mark must be witnessed:

Witness Signature (if applicable): ____

Witness Name/Title:____

C: Case Manager - Original
Residential Program (if applicable)
Day Program (if applicable)