



**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Health Insurance Portability and Accountability Act of 1996

45 C.F.R. § 164.508

Name of person/organization disclosing health information:

**Department of Economic Security / Division of Developmental Disabilities (DDD)**

Name of individual whose protected health information may be disclosed: \_\_\_\_\_

\_\_\_\_\_

The protected health information which may be disclosed includes address and applicable individual, parent or guardian contact information as well as any health care information relating to the individual that the DDD determines is needed by the caller in order to provide appropriate medical treatment to the individual or to provide for the individual's safety and welfare until the person's parent guardian, or responsible party is able to resume custody of the individual. This information will be disclosed by DDD to a caller who obtains the DDD telephone number from an identification tag provided to the individual by DDD. Upon receipt of a call for this information, DDD will verify that the caller obtained the phone number from the identification tag. The information will be disclosed to the caller (generally expected to be law enforcement, emergency medical providers, or individuals attempting to assist the individual) in the event the individual named above becomes ill, lost, injured or otherwise physically or mentally impaired and needs assistance.

The release of protected health information will be to assist rescuers in aiding the individual named above.

This authorization will expire on the date that the individual is no longer eligible for DES/DDD. I understand that once this expiration condition occurs, the Department will not be able to provide information pursuant to this release even though the individual may still be wearing the identification tag.

I understand that I may revoke this authorization at any time by written notice to DDD, except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation.

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 except as provided under state or federal law.

I understand that once the records and information authorized herein are disclosed, they could be re-disclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, health care service providers generally are bound by law to maintain the confidentiality of health information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.

I understand that I may have a copy of this signed authorization if I request it.

\_\_\_\_\_ Date signed: \_\_\_\_\_  
(Print full name of individual/client or personal representative)

\_\_\_\_\_ Description of personal representative's authority  
Signature of individual/client or personal representative (If applicable)

\*Note: This authorization was revoked/ withdrawn in writing on (date): \_\_\_\_\_

Signature of staff: \_\_\_\_\_

**A Facsimile or Photocopy of this Authorization is Considered to be as Authentic as the Original**