AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION UNDER A SUPPORTED DECISION-MAKING AGREEMENT

NAME OF ADULT WITH A DISABILITY

_____
Last First Middle

DATE OF BIRTH _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALTERNATE PHONE** (_____)_____

I ALLOW THE FOLLOWING PERSON, PROVIDER OR ORGANIZATION TO RELEASE MY INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION:

Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____ Fax (_____)_____

Name of Supporter Who Can Receive the Confidential Information?

Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____ Fax (_____)_____

REASON FOR RELEASE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ School
- ☐ Employment
- ☐ Other_____

WHAT INFORMATION CAN BE RELEASED? Complete the following by choosing those items that you want released. Check one of the following:

1. HEALTH/MENTAL HEALTH INFORMATION

☐ All health/mental health information:
☐ Only the following health/mental health information: _____

Your initials are required to release the following information:

____ Psychotherapy Notes
____ HIV/AIDS Test Results/Treatment
____ Drug, Alcohol, or Substance Abuse Records

2. CASE-RELATED INFORMATION

☐ My entire case file/records
☐ Only the following case-related information: _____

3. EDUCATION/SPECIAL EDUCATION INFORMATION

☐ All education/special education records
☐ Only the following education/special education records: _____

4. EMPLOYMENT INFORMATION

☐ All employment records
☐ Only the following employment information: _____

5. FINANCIAL/PROPERTY INFORMATION

☐ All financial/property records

☐ Only the following financial/property information: _____

_____

_____

6. HOUSING INFORMATION

☐ All housing records

☐ Only the following housing information: _____

_____

_____

7. SUPPORTS AND SERVICES

☐ All records related to any supports and services provided to me

☐ Only the following supports and services information: _____

_____

_____

PURPOSE OF AUTHORIZATION: I have entered a supported decision-making agreement with my supporter. I only authorize the release of my confidential information to my supporter so that my supporter can help me obtain a copy of the confidential information, help me understand the information contained in this confidential information and help me communicate my decisions based on this confidential information. My supporter shall ensure that my confidential information is kept privileged and confidential and is not subject to unauthorized access, use or disclosure. My supporter may only release my confidential information to any other person, provider or organization with my permission. I also retain the right to obtain my confidential information on my own without the help of my supporter.

EFFECTIVE TIME PERIOD. This authorization is valid until my death; the end of my supported decision-making agreement; my permission is withdrawn; or until (date): Month _____ Day ____ Year ____.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to release information to my supporter.

SIGNATURE AUTHORIZATION: I agree to the release of my confidential information to my supporter. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that I cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. I have read and agree with how my confidential information may be used and shared with my supporter.

SIGNATURE _____ _____

Signature of Adult with Disability **DATE**