California Department of Developmental Services
State of California Health and Human Services Agency

AUTHORIZATION FOR RELEASE OF CONSUMER INFORMATION

Consumer Information			
Last Name	First Name	Middle Name	Date of Birth
Address	City/State/Zip		UCI Number

Person/Organization Providing Information

- ☐ Department of Developmental Services
- ☐ Porterville Developmental Center
- ☐ Canyon Springs Developmental Center
- ☐ STAR home: _____
  (STAR Home Location)
- ☐ Other: _____

Person/Organization Receiving Information

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Email: _____

☐ Information may be sent **and** received between the above listed parties.

When an Authorization is received by DDS, consumer/health information may be used or disclosed for the purpose specifically listed in the authorization.

☐ **Date range of records to be released:** _____ to _____

OR

☐ **Release records authorized below, regardless of date.**

Confidential Patient Information: See Welfare & Institutions Code, Section 4514 HIPAA Privacy Rule CFR Section 164.508

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Description of Information to be Released:
(All records collected, maintained, used, disclosed by DDS, are Mental Health Records.)

☐ Personal identifier, Diagnosis, and/or Demographic Information
☐ Individual Program Plan (IPP)
☐ Medication Records
☐ Clinical Lab Reports
☐ Physical Examination/Medical History
☐ Substance Use Disorder (SUD) Treatment Records
☐ Billing/Claim/Purchase of Service Information
☐ Legal Documents
☐ Other (Please specify): _____

THIS AUTHORIZATION ONLY PERMITS ONE TIME DISCLOSURE OF THE FOLLOWING RECORDS. SUBSEQUENT DISCLSOURES WILL REQUIRE ANOTHER AUTHORIZATION.

Specially Protected Records	Consumer Initials
☐ HIV/AIDS Test Results	
☐ Genetic Test Results	

Purpose for Release of Information

☐ At the Request of the Consumer (Only if Consumer initiates Authorization)
☐ Legal Representation
☐ Other: _____

Confidential Patient Information: See Welfare & Institutions Code, Section 4514 HIPAA Privacy Rule CFR Section 164.508

AUTHORIZATION FOR RELEASE OF CONSUMER INFORMATION

Purpose for Release of Information

I understand:
I am authorizing the release of (agreeing to share) my personal health information. When information is sent to/from a Department of Developmental Services, the other person/organization will know that I have received developmental services.

I am signing this Authorization voluntarily (by my own choice-without force), and my treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.

The information released may be re-shared with others and is no longer protected if it is disclosed to anyone other than a covered entity.

Reasonable fees may be charged to the person requesting the information in order to cover the cost of copying and postage.

I have the right to receive a copy of this Authorization.

Right to modify or revoke: Prior to any release of information, I have the right to modify or revoke this Authorization (change my mind and not allow information to be released), unless:

1. DDS has already provided records in reliance on the authorization; or
2. This authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Confidential Patient Information: See Welfare & Institutions Code, Section 4514 HIPAA Privacy Rule CFR Section 164.508

AUTHORIZATION FOR RELEASE OF CONSUMER INFORMATION

To modify or revoke, I will send a written request to:

☐ Department of Developmental Services
☐ Porterville Dev. Center
☐ Canyon Springs Dev. Center
☐ STAR home: _____
(STAR Home Location)
☐ Other: As identified above as the "Person/Entity Providing Information."

If not revoked, this Authorization will expire at the end of:

☐ Date (specify): _____
☐ 6 months
☐ One year
☐ Event (specify): _____

Signature of Consumer OR ☐ Personal Representative	Date
Printed Name	
☐ The individual is a current consumer, I have reviewed this Authorization with the consumer prior to the signing the form. ☐ I have verified authority of the Personal Representative to sign on behalf of the Consumer.	
Signature of staff member	Date
Printed Name	

Confidential Patient Information: See Welfare & Institutions Code, Section 4514 HIPAA Privacy Rule CFR Section 164.508