



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 DISCLOSURES WILL
REQUIRE ANOTHER AUTHORIZATION.**

Specially Protected Records	Consumer Initials
<input type="checkbox"/> HIV/AIDS Test Results	
<input type="checkbox"/> Genetic Test Results	

Purpose for Release of Information

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

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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.

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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 <input type="checkbox"/> Personal Representative	Date
Printed Name	
<input type="checkbox"/> The individual is a current consumer, I have reviewed this Authorization with the consumer prior to the signing the form.	
<input type="checkbox"/> I have verified authority of the Personal Representative to sign on behalf of the Consumer.	
Signature of staff member	Date
Printed Name	

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