Alaska Department of Health
Division of Public Assistance

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
Used for disability determination needed for program eligibility

Name:_____

SSN: _____ DPA Client ID #: _____ Date of Birth: _____

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):
OF WHAT: **All my medical records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All record and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric, and other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell Anemia
   - Records which may indicate presence of a communicable or noncommunicable disease and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennia assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teacher's observations and evaluations.
4. Information created within 12 months after the date of this authorization is signed, as well as past information.

FROM WHOM: All medical sources to include:

- All educational sources
- Social workers/rehabilitation counselors
- Consulting examiners used by Social Security Administration (SSA) and Disability Determination services (DDS)
- Employers, insurance companies, worker's compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY DIVISION OF PUBLIC ASSISTANCE and DISABILITY DETERMINATION SERVICES (as needed). Additional information to identify the subject (e.g., other names used) and/or specific source of the material to be disclosed:

TO WHOM: **The State of Alaska department of Health, and Department of Labor's Disability Determination Services, including doctors and other professionals consulted during the disability determination process.**

EXPIRES: This authorization is good for 12 months from the date signed below (my signature).

I understand the requested information shall be used solely in the decision of a claim for disability. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing or by signing the organization's written revocation form, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider required to abide by federal privacy regulations, the released information may no longer be protected. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

_____ _____
Individual authorizing disclosure signature Date

☐ Self ☐ Parent of Minor ☐ Other Personal Representative (explain: _____)

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A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting the recipient from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

REVOCATION SECTION

The revocation section should only be completed IF the client wishes to revoke authorization. ***The revocation section should NOT be completed when the authorization is signed initially.***

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Applicant/Recipient or Authorized Representative	Date
Printed Name of Applicant/Recipient or Authorized Representative	Description of Authorized Representative's Authority
Witness signature if signed with an X	Printed name of witness
Signature of Parent/Guardian (if the applicant/recipient is a minor)	Date
Printed Name of Parent/Guardian	