Aging and Disability Services Division

Authorization to Release or Request Information

If you need help with this form, ADSD staff will help explain it. You can also read the ADSD Notice of Privacy Practices for more information.

Authorization to Share the Aging and Disability Services Division (ADSD) Records of:

Name: Last First Middle **Date of Birth:**

Mailing Address: Number City State Zip Code

The records will be shared to (select all that apply):

☐ Nevada Health Authority ☐ Division of Social Services ☐ School District
☐ Primary Health Care Provider (specify)
☐ Community Provider (specify)
☐ Managed Care Organization (specify)
☐ Primary Insurance (specify)
☐ Other (specify below):

Name of business, organization, facility or program: (If Applicable)

Name: Last First Middle **Title**:

Address: Number City State Zip Code

Telephone Number: **Fax Number:** **E-mail Address**:

The person giving this permission is related to me as:

☐ My Authorized Representative/ Designee/ Legal Guardian ☐ Parent ☐ Self
☐ Other (Describe Including First, Last Name)
☐ **I am not asking ADSD to share my records now**. Please place this in my file for future use.

Permission: The ADSD programs I choose below may share my private information. Information may be given by secure computer data transfer, fax, in-person, mail, or verbally.

Check the programs you approve below:

☐ ADSD Administration
☐ Adult Protective Services (APS)
☐ Autism Treatment Assistance Program (ATAP)
☐ Communication Access Services (CAS)
☐ Developmental Services (DS)
☐ DS Intermediate Care Facility (ICF)
☐ Fetal Alcohol Spectrum Disorder Treatment Assistance Program (FASTA)
☐ Nevada Early Intervention Services (NEIS)
☐ Office for Consumer Health Assistance (OCHA)
☐ Office of Community Living (OCL)
☐ Taxi Assistance Program (TAP)
☐ Other Approved Program(s)(Specify):

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Reason for sharing: ADSD shares records to determine eligibility and/or to coordinate services. Unless the law requires it, services, payment, enrollment, or eligibility is not decided based on this permission.

I approve the following records to be shared or received as checked below:

- ☐ Assessments
- ☐ Consultation Reports
- ☐ Developmental Screeners
- ☐ Educational Records
- ☐ Financial Records
- ☐ Intake Evaluations and Records
- ☐ Legal Records
- ☐ Other:

- ☐ Lab/ X Rays/ Imaging Studies/ Test Results
- ☐ Medical information (including but not limited to medical and hospital records).
- ☐ Progress Notes and Treatment Plans (including but not limited to Individualized Family Service Plan, Care Plans, Person Centered Service Plans)

☐ The following records ONLY:

Request for Information – The section below approves ADSD to request your personal information from specific people.

The ADSD TAP program is requesting the records selected above.

Date Range: Between and or ☐ the last five (5) years.

I approve ADSD to request my information from necessary covered entities* and/or the person approved below:

Name: Last First Middle **Title**:

Name of business, organization, facility or program: (If Applicable)

Address: Number City State Zip Code

Telephone Number: **Fax Number:** **E-mail Address**:

*A covered entity is an organization or individual that is responsible for following HIPAA rules. They must keep your protected health information safe.

Consent:

I understand that:

- I can ask for a copy of the privacy rules.
- I do not have to sign this form.
- I can cancel this permission at any time. I must turn in my request in writing to ADSD if I want to cancel my permission.
- ADSD will not share any health information after I end the permission. I know information may have been shared before it was cancelled.
- A copy of this form can be accepted; it does not have to be original.
- If I think I have been treated unfairly because my HIV/AIDS-related information was shared, I can contact the Office of Civil Rights.
- ADSD shares information to make decisions about my services.
- If a recipient receives information from ADSD based on this release, they may share it. Information shared by the recipient is longer be protected by federal or state law.

I will not hold ADSD employees responsible for sharing information to those listed on this form.

My permission will end:

☐ One (1) year from the date of signature, unless otherwise specified below.

☐ Other:

This permission will automatically end when my case is closed.

Authorized By (Print Last, First Name) **Date**

Authorized By (Signature) **Date**

Signature of ADSD Employee **Date**

Clear Form

What Laws Protect This Information?

- The "Confidentiality and Consent Requirements for Substance Use Disorder Patient Records" law is about the privacy of alcohol and drug treatment of patient records (42 CFR 2.31).
- The Family Education Rights and Privacy Act (FERPA) is about protecting privacy of educational or early intervention records (34 CFR 99.30-99.39).
- Laws about the disclosure of mental health information (45 CFR 164.508).
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to protect your health information for treatment, payment, and/or health care operations (45 CFR 164.506).

Privacy and Information Sharing
ADSD has decided not to share information about:

- Drug and alcohol treatment
- HIV/AIDS health information
- Mental health treatment

If someone receives private information, they cannot share it. They also cannot use it without written permission from the person it is about. The only exception to this is whether federal or state law allows it.

This permission is written consent for information protected by FERPA.

Instructions for Completion of Authorization Form

"You" refers to the subject of the records.

Purpose: You should use this form when you want ADSD to be able to share private information about you with another person (including an attorney, a legislator, or a relative). You may give permission to share all confidential records ADSD has about you. You may limit your permission to specific records. You may limit which programs in ADSD can use/share your information. This form will also allow ADSD to talk about your situation verbally or in writing.

Notice to Clients: Most client information ADSD has is private. It will not be shared with others unless you give permission, or if sharing is allowed by law. You can read the ADSD Notice of Privacy Practices for information on how ADSD programs covered by HIPAA share protected health information and your privacy rights. You can also ask the person who gave you this form.

Use: You may fill out this form electronically or on paper. Use the tab key on a computer to move between fields.

A separate form must be completed for each person whose records are requested, including children.

Parts of Form:

Name: Provide your full name or the name of the person whose records are requested if you are acting for someone else. Your full name will help us identify you differently from other people with similar names to yours.

Date of birth: Please tell us when you were born. This will help us identify you in case you have the same name as someone else.

Mailing Address: Provide your full mail address so information you request can be sent to you.

Share To: Tell ADSD who is allowed to see your records. Please check all the boxes that apply. Fill out this section with as much information as you can. We will contact the person or organization you have listed. They will have access to your information.

Permission: This says you allow ADSD to send your information in different ways.

ADSD Programs: Please choose the ADSD programs allowed to share your records. Write in the name of program in “Other” if it is not in the list.

Reason for Sharing: This information explains why ADSD is asking to send or receive your records.

Records to be Shared: Tells us what records that you want shared. You may give permission for all or part of your ADSD client or other confidential records. You may also limit sharing to client records held only by the ADSD programs and records marked in the section above.

Request for Information: This says you allow ADSD to request your records. If ADSD is asking for records from a specific person or organization, they will tell you who.

Consent: This section tells you about what you should understand if you sign this form. It also explains when your permission will end.