Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION

Helping people. It's who we are and what we do.

Dena Schmidt
Administrator

Authorization to Release Information

☐**Aging and Disability Services Division (ADSD) Administration**	☐**Adult Protective Services (APS)**	☐**Autism Treatment Assistance Program (ATAP)**	☐ **Communication Access Services (CAS)**	☐**Developmental Services (DS)**
☐**Intermediate Care Facility (ICF)**	☐**Long-Term Care Ombudsman Program (LTCOP)**	☐**Nevada Early Intervention Services (NEIS)**	☐**Office of Community Living (OCL)** - **Community Options Program from the Elderly (COPE)** - **Home and Community Based Services Waiver for the Frail Elderly (HCBS FE)** - **Home and Community Based Services Waiver for Person's with Physical Disabilities (PD)** - **Personal Assistance Services (PAS)**	
☐**Office for Consumer Health Assistance (OCHA)**	☐**Senior Rx/Dx**	☐**Taxi Assistance Program (TAP)**	☐**Other (Specify below)**	

(Individual Legal Name Printed) (Date of Birth)

(Individual Mailing Address) (City, State, Zip Code)

I authorized ADSD to: ☐Release information to: ☐Receive information from:

Name of person/provider/organization/facility/program:

Phone: Fax:

Reason for Request: To determine the individual's eligibility and/or to coordinate services.

☐Other (specify):

This consent is provided in accordance with 42 CFR 2.31 regarding the confidentiality of alcohol and drug treatment patient records; 34 CFR 99.30 – 99.39 regarding disclosure of educational or early intervention records; 45 CFR 164.508 regarding the disclosure of mental health information; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is to be used only to facilitate treatment, payment, and/or health care operations (45 CFR 164.506). The Participant's service, payment, enrollment, or eligibility for benefits will not be conditioned on the provision of the authorization, except as permitted by law.

Specific Information Authorized to Be Released: Use/Disclosure of information is authorized below by selection box.

Records Date Range: From: To**:**

	TYPE OF INFORMATION		
☐	Assessments	☐	History and Physical
☐	Developmental Screeners	☐	Lab / X rays /Imaging Studies/ Test results
☐	Intake Evaluations and Records	☐	Consultation Reports
☐	Legal Records	☐	Educational Records+
☐	Medical information including but not limited to medical and hospital records; including but not limited to HIV/ AIDS related information**	☐	Progress Notes and Treatment Plans including but not limited to Individual Family Support Plan (IFSP), Care Plans, Service Plans
☐	Mental Health information including psychological testing and psychiatric evaluations***	☐	Financial Records
☐	Other		

* ADSD has elected not to disclose or release information relating to drug and alcohol treatment.

With some exceptions, HIV/AIDS – related health information, or mental health treatment information may be re-disclosed by the recipient. **The recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without the specific written consent of the person to whom it pertains, unless permitted to do so under federal or state law.

***Information from mental health clinical records may be released if there is a **demonstrable need for the information**, provided that the disclosure will not reasonably be expected to be detrimental to the participant or another person.

+ If the authorized information is protected by the Family Educational Rights and Privacy Act it may not be disclosed without the written consent of the person to whom it pertains unless otherwise provided for in federal or state law. This authorization serves as written consent for the release of the aforementioned information.

I understand that:
I may request and obtain a copy of the Division's confidential information policy.
I do not have to sign this authorization; I understand that I may be denied treatment in some circumstances if I do not sign this consent because information may be required to determine my eligibility for services.
I may cancel this authorization at any time by submitting a written request to the Aging and Disability Services Division, except where a disclosure has already been made with my prior authorization.
A photocopy or fax of this form is as valid as the original.
If I experience discrimination because of the release or disclosure of HIV/AIDS – related information, I may contact the Office of Civil Rights to file a complaint.
ADSD releases information in the scope of their duties to make determinations necessary for eligibility and on-going service requirements.
Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.
I release ADSD employees from any liability arising from the release of information to the person/entity designated on page 1.

☐ I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program identified as often as necessary.

My authorization will expire:

☐ If I am no longer receiving services from the Aging and Disabilities Services Division or it's programs

☐ One (1) year from the date of signature, unless otherwise specified by a condition or event, whichever is earlier

☐ Other: ______________________
(Please describe)

Relationship: ☐Parent ☐Legal Guardian/Designee ☐Custodian ☐Self ☐Other

____
(Parent/Guardian/Custodian/Self Printed Name)

____
(Parent/Guardian/Custodian/Self Signature) (Signature Date)

____
(Signature of ADSD Employee) (Signature Date)