Authorization for Release and Exchange of Information

Individual name: ____

Date of Birth: _______________ **SSN**: ________________________ **and/or Medicaid ID**: ____________________

The following organizations/providers are hereby authorized to release, exchange, and share oral and written protected health information (PHI) with each other regarding the Individual named above:

Developmental Pathways, Inc. and:

- Physicians involved in my care.
- HCBS Providers involved in my care.
- Home Health Providers involved in my care.
- Therapists involved in my care.
- Hospitals and related facilities involved in my care.
- Regional Accountable Entity (RAE) (as listed here): ____
- School District (as listed here): ____
- Others (as listed here): ____

Information to be released, exchanged, and shared:

- Health information including but not limited to diagnosis, treatment, history, master file records, billing records; treatment notes; service and related plans, and information pertaining to home and community-based services (HCBS) and supports

- Other (as described here): ____

Purpose(s) or need for which the information is to be used and disclosed:

- Coordination/Continuity of Care
- Case Management
- Assessment
- Benefits Coordination/Acquisition
- Disability Determination
- Program Compliance
- Other (as listed here): ____

I understand that HIV/AIDS related information and/or records, psychotherapy notes, genetic testing information or notes, sickle cell anemia related information and/or records and drug/alcohol diagnosis, and treatment and referral information will not be released without a separate release specifically authorizing such release signed by you.

I understand that I make revoke this Authorization at any time by giving written notice to Developmental Pathways, except to the extent that Developmental Pathways has already taken action on this request. This Authorization will expire on _____________ (MM/DD/YYYY), or, if left blank, one year from the date of my signature (whichever event comes first). I release Developmental Pathways from all liability for disclosing the requested information.

Authorization: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is released, it carries with it the potential for unauthorized re-disclosure, and it may no longer be protected by federal confidentiality rules such as HIPAA.

Authorization for Release and Exchange of Information

A copy or facsimile of this Authorization may be used with the same effectiveness as the original.

Individual or Person Authorized to Sign for Individual: ____

If not the individual, please indicate how authorized to sign:

☐ Guardian ☐ Parent (individual is a minor) ☐ Other: ________________________

Signature: ____Date: _______________