

HCBS/Autism Waiver
AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name: _____ SS #: _____
Date of Birth: _____ Telephone H#: _____ Wk#: _____
Street Address _____ City: _____ State: _____ Zip: _____

I hereby authorize the two agencies and/or persons listed below to exchange information regarding my case.

Agency &/or Person _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax _____ E-mail: _____

Agency &/or Person _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax _____ E-mail: _____

All types of information listed below will be used unless otherwise noted by initialing below:

- | | |
|---|---|
| <input type="checkbox"/> All Records/Information | <input type="checkbox"/> Psychological Evaluation(s), IQ Scores & Tests |
| <input type="checkbox"/> Dental | <input type="checkbox"/> School Records |
| <input type="checkbox"/> Medical Records, including Diagnosis | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Program Plans, Evaluations & Assessments | <input type="checkbox"/> Other: _____ |

This information may be released in the following format(s): Audio/Visual Electronic Verbal
 Written Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent the action has already taken place. I understand that if I revoke this authorization I must do in writing and present my written revocation to the information management department. Unless otherwise revoked, this authorization will expire on _____ / _____ / _____
(Not to exceed one year from date of signature).

I have read the above Authorization for Release of Information / Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date: _____ / _____ / _____ Signature of Person Served: _____

Date: _____ / _____ / _____ Signature of Authorized Representative: _____

Representative: _____
(*Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian or Authorized Representative: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Relationship to the Person: _____