IDAHO DEPARTMENT OF HEALTH & WELFARE

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Information

Client Name_____ Date of Birth _____ Telephone_____
(First, MI, Last)

Mailing Address_____ State_____ Zip Code_____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requestor Name (if different than client)_____ Telephone _____

Mailing Address_____ State_____ Zip Code_____

Authorization Details

I authorize the following individual, organization or business _____

_____

to disclose my confidential information to: Name_____

Address:_____ State_____ Zip Code_____

for the purpose of _____

*Please describe in detail the information to be disclosed*_____

_____

_____

_____

This authorization will expire in 6 months unless another date or event is specified here_____

_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare office. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your signature_____ **Date** _____

Your signature must be notarized if you submit this request by fax, mail or e-mail and we cannot verify it with information already on file.