Department of Health & Human Services | Services for People with Disabilities

# Authorization to furnish information

Form 1-2 Version Date: July 2026

**PRIVACY NOTICE:** The information you provide on this form will be used to determine eligibility for division services. It will be used only by DHHS, if needed, or by a person or party contracted with DHHS. Without this information, we cannot make a determination about your eligibility. This data is part of record series 15376.

Name: _____ Date of birth: _____

The following have my permission to disclose my protected health information:

- ☐ School District: _____
- ☐ Vocational Rehabilitation: _____
- ☐ Mental Health Provider: _____
- ☐ Physician: _____
- ☐ Other: _____

You are hereby authorized to release to the **Department of Health & Human Services Division of Services for People with Disabilities (DHHS DSPD)** or its authorized representatives, verbally or in any written form, any information you have regarding the following subjects:

| | | |
|---|---|---|
| ☐ Developmental testing | ☐ Inpatient records | ☐ Vocational testing |
| ☐ Psychological/cognitive tests | ☐ Brain injury records | ☐ IEP/educational testing |
| ☐ Out patient records | ☐ Physical examination records | ☐ Other: _____ |

Please include records from _____ to _____

(If the information released relates to drug or alcohol abuse, the records are protected by federal confidentiality laws and you are prohibited from making further disclosures of this information without the specific written authorization of the person of whom it pertains or as permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal law restricts using drug or alcohol abuse information for criminal investigation or prosecution.)

The purpose of this disclosure is to establish eligibility for DSPD services. Disclosure Expiration Date:

- I understand that I may refuse to sign this Authorization, and my health care provider cannot refuse to provide treatment, payment, or deny eligibility for benefits based upon my refusal.
- I understand that I may revoke this authorization in writing at any time. I understand that my revocation is not effective until received by the health care provider. My revocation is not effective to the extent the health care provider already released information in reliance on this authorization.
- I understand that federal privacy laws may no longer protect information released to DSPD and the information may be re-disclosed.
- I understand that this information is required by the Department of Health & Human Services, Division of Services for People with Disabilities to determine eligibility.

I, the Individual and/or Authorized Personal Representative, understand that by signing below am requesting the Division of Services for People with Disabilities collect information about me to see if I am eligible for services.

Signature: _____ Date: _____

Signer is: ◯ the individual named above ◯ the individual's legal guardian

Authorized personal representative's name: _____