AGENCY FOR PERSONS WITH DISABILITIES (APD)

CONSENT TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

YOUR LAST NAME	YOUR FIRST NAME	DATE OF BIRTH
STREET ADDRESS	STATE	ZIP
HOME TELEPHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

[___] I hereby freely and voluntarily consent and authorize the Agency for Persons with Disabilities ("APD), or its agents or representatives, ***to obtain*** my protected health information from the person(s), agencies, institutions, or entities stated below for the purposes of treatment, payment, and health care operations.

[___] I hereby freely and voluntarily consent and authorize the Agency for Persons with Disabilities ("APD"), or its agents or representatives, ***to obtain only specific portions*** of my protected health information from the person(s), agencies, institutions, or entities stated below for the purposes of treatment, payment, and health care operations.

[___] I hereby freely and voluntarily authorize the Agency for Persons with Disabilities ("APD"), or its agents or representatives, ***to discuss, access, use, and/or disclose matters*** related to my protected health information to or from the person(s), agencies, institutions, or entities stated below for the purposes of treatment, payment, and health care operations.

The information requested below will be accessed, used, or disclosed for the following purposes:

[___]	Medical Reports	[___]	Social Service Reports
[___]	Academic Records and Plans	[___]	Speech and Hearing Reports
[___]	Habilitation Plans / Support Plans	[___]	Physical Therapy Reports
[___]	Psychological Reports	[___]	Occupational Therapy Reports
[___]	Other (Please specify)		

Name, address, telephone number, email address, and/or fax number of person, agency, institution, or entity from whom my protected health information is to be obtained:

Name, address, telephone number, email address, and/or fax number of person, agency, institution, or entity to whom my protected health information may be discussed and/or disclosed:

- I understand that my protected health information may be accessed, discussed, used, and/or disclosed for purposes of treatment, payment, healthcare operations, and as otherwise permitted or required by law.
- I also understand that information disclosed under this Consent to Obtain or Release Protected Health Information might be re-disclosed by the recipient and it may no longer protect my health information under federal or state law, if the recipient of the information is obligated to comply with the requirements of HIPAA.
- I understand that I may revoke this Consent by writing to APD, except to the extent that action has already been taken based on this Consent to Obtain or Release Protected Health Information.
- I know that I may inspect or copy any information used / disclosed under this consent.

This consent expires on _____. I understand that if this consent has not been revoked by me or it does not specify a consent expiration date, it will automatically expire ninety (90) calendar days from the date of signing the consent.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Client		Date	

If you are a client's legal representative, you must state your title and provide documentation proving your legal authority to act on behalf of the client.

Signature of Legal Representative		Date	Relationship of Legal Representative