ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Rehabilitation Services Administration

AUTHORIZATION FOR RELEASE OF RSA RECORDS
(Including HIPAA Covered Records)

I, the undersigned individual or legal representative, hereby authorize the Rehabilitation Services Administration (RSA) to use or disclose confidential client information regarding:

Name _____

Also Known As (AKA) / Maiden Name _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Date of Birth _____ Authorization Expiration Date _____ Phone Number _____

The information may be disclosed to and used by the following:

Name: _____ Attention: _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Phone Number _____ Fax Number _____

Requested Method of Delivery: ☑ Mail ☑ Verbal ☑ Pick-up ☑ Email ☑ Fax

Email Address _____ Relationship to RSA Client Parent

The date(s) of service and the type(s) of information to be used or disclosed are as follows:

☐ RSA Case Notes

☐ Medical Records

☐ Functional Capacity Evaluation

☐ Vocational Evaluation

☐ Vendor Progress Notes

☐ Psychological / Neuropsychological Evaluation

☑ Other
Allow parents to receive copies of VR forms, letters, & documentation via email or mail regarding client

☑ Other
Progress/updates with VR counselor. Verbal/email/mail communications regarding participation in program.

☐ All RSA Records

The purpose of this disclosure or use is:

To participate in ongoing VR meetings and provide input on service delivery. Notifications of meeting and appointments.

See page 2 for EOE/ADA/LEP/GINA disclosures

- Controlling federal and state statutes limit RSA release of confidential client information. I understand by signing this release I authorize release of my confidential information to the named recipient.
- RSA may be in possession of secondary source information that is prohibited from re-release. This information may be requested from the original source through the client.
- Reports and evaluations generated by RSA are intended for the sole purpose of planning and administering an individualized rehabilitation program.
- RSA will not accept liability for the use of this information in any other manner than intended and authorized by the client.
- Confidential client information may not be used by the recipient for purposes not stated in this authorization.
- The recipient may not release confidential client information to others.
- If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.
- I understand that except to the extent that the disclosure authorized has been acted upon prior to the receipt of any revocation I may revoke this authorization at any time by written notice to RSA.
- I understand that I may have a copy of this signed authorization if I request it.
- The parent or legal guardian must sign this authorization if the RSA applicant/client is a minor (under age 18) or has a legal guardian.

RSA Applicant/Client's Signature _____ Date _____

Parent or Legal Representative's Signature _____ Date _____

If signed by the Legal Representative, indicate your relationship to the individual and provide appropriate documentation to verify your authority.

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

A copy of this completed, signed and dated form must be given to the Legal Representative on behalf of the individual.