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**WHOSE Records to be Disclosed:**

First			Middle			Last		
NAME								
SSN				Birthday (mm/dd/yy)				
<b>SRS USE ONLY: NUMBER HOLDER (If other than above)</b>								
NAME								
SSN								

**AUTHORIZATION TO DISCLOSE INFORMATION TO  
The Social and Rehabilitation Services' Disability Determination Services (DDS)**

\*\* PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW \*\*

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

**OF WHAT** All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
  - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
  - Drug abuse, alcoholism, or other substance abuse
  - Sickle cell anemia
  - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases
  - Gene-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
- Information created within 12 months after the date this authorization is signed, as well as past information.

**FROM WHOM**

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SRS
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

**THIS BOX TO BE COMPLETED BY SRS (as needed)** Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

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**TO WHOM**

The State agency authorized to process my case (Disability Determination Services), including contract copy services, and doctors or professionals consulted during the process.

**PURPOSE**

Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet the definition of disability.

**EXPIRES WHEN**

This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties.
- I may write to SRS and my sources to revoke this authorization at any time.
- SRS will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read this form and agree to the disclosures above from the types of sources listed.

**INDIVIDUAL** authorizing disclosure:

IF not signed by subject of disclosure, specify basis for authority to sign  
Parent of minor      Guardian      Other personal representative (explain)

**SIGN** ▶

(Parent/guardian sign here if two signatures required by State law) ▶

Date Signed

Street Address

Phone Number (with area code)

City

State

ZIP

**WITNESS (ONLY required if the claimant signed with an "X")**

I know the person signing this form or am satisfied of this person's identity:

**SIGN** ▶

Phone Number (or Address)

Phone Number (or Address)

*This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under: P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.*