

# 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 español. 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: \_\_\_\_\_ City: \_\_\_\_\_ 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: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Authorization Details

*I authorize the following individual, organization or business:*

*to disclose my confidential information to: Name:*

Address: \_\_\_\_\_ City: \_\_\_\_\_ 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: \_\_\_\_\_

Notary signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

*Your signature must be notarized if we are unable to verify your identity and you submit this request by mail.*