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DD-1103 (4-2005)

WHOSE *Records to be Disclosed:*

First *Middle* *Last*

NAME

SSN	Birthday (mm/dd/yy)

DCF USE ONLY: NUMBER HOLDER (If other than above)

NAME

SSN

AUTHORIZATION TO DISCLOSE INFORMATION TO The Department for Children and Families 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:**

1. **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)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **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.**
4. **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 DCF
- Employers
- Others who may know about my condition
- (family, neighbors, friends, public officials)

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

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 DCF and my sources to revoke this authorization at any time.
- DCF 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.