DELAWARE HEALTH AND SOCIAL SERVICES

Division of Developmental Disabilities Services

HIPAA COMPLIANT CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
Pursuant to 45 CFR 164.508

Individual (DDDS Service Recipient):

Name:		**Birthdate:**
Street Address:		
City:	**State:**	**Zip:**

I, or my Legal Guardian, herby authorizes the Division of Developmental Disabilities Services (DDDS) to disclose my Personal Health Information and/or any other documents that is requested on this consent form to the designee identified below:

Requesting Individual (to whom the information will be sent):

Name:		**Relationship:**
Street Address:		
City:	**State:**	**Zip:**

Specific information to be released:

☐ Access to my Electronic Case Record (*please select the section(s) that will be available to view)*

☐ Case Notes ☐ Person Centered Plan (ELP) ☐ Incident Reports (GER)

☐ Medical ☐ Behavior Support Plan ☐ Individual Data Form

☐ Release of my Person Centered Plan (paper form)

☐ Release of my Medical Record (specify what records will be released below):

☐ Release of information pertaining to an incident or Reportable Incident (specify what records will be released):

_____

☐Other: (Please Explain):

_____

Reason for the release of information:

☐ At the request of the individual

☐ Other:

_____

Purpose for the information:

_____

Restrictions to the release: (*if applicable)*:

_____

My signature indicates that I know exactly what information is being disclosed and have had the chance to correct and change the information to make sure it is correct and complete. I am aware that this consent can be revoked in writing at any time.

My signature also means that I have read this form and/or have had it read to me and explained in a language I can understand. All blank spaces have been filled in except for signatures and dates.

I have received a copy of this consent for my records.

This consent ends one year from the date signed unless revoked by me in writing before that time. This consent is effective immediately and shall stay in effect as stated.

_____	_____	_____
(Individuals signature or "X")	(Date signed)	(Witness/Date signed)
_____	_____	_____
(Individuals guardian, if applicable)	(Date signed)	(Witness/Date signed)

To be completed if the individual has a guardian:

Guardian Verified: ☐ Yes ☐ No

Verified by who:

First and Last name:	**Relationship to the individual:**
Company Name:	**Date Verified:**

Please send all consents to: Stockley Center
Health Information Management Department
26351 Patriots Way
Georgetown, DE 19947