Maryland State Department of Education
Division of Rehabilitation Services
Request for Confidential Information

Return to: _____
Office Address: _____

_____

Office Phone: _____
Office Fax: _____

TO:

Name of Organization: _____
Name of Provider: _____
Provider Address: _____

_____

Provider Fax Number: _____

RE:

Name of Consumer: _____
Consumer Address: _____

_____

Last 4 Digits of Social Security Number: _____
Participant ID: _____
Date of Birth: _____

Disclose or disclosure means the communication of personal information about an applicant or eligible individual for vocational rehabilitation services or the release of records containing personal information about an applicant or eligible individual for vocational rehabilitation services. COMAR 13A.11.06.02B(3).

My signature below authorizes the above-named source to disclose to the Division of Rehabilitation Services (DORS) the following protected health information (PHI) and/or other confidential information, which may include:

- Information regarding treatment, hospitalization and/or outpatient care for my impairments, including summaries and reports of psychological or psychiatric impairment(s) (except "psycho-therapy notes" as defined in 45 CFR 164.501), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS) or tests for HIV/AIDS, or sexually transmitted diseases; and

- Information about how my impairment(s) affect my ability to complete activities of daily living and work activities:
  - ☐ Hospital Admission/Discharge Summaries
  - ☐ Social History
  - ☐ Psychological or Psychiatric Reports
  - ☐ Medical Documentation
  - ☐ Transcripts/School Records
  - ☐ Social Security Records
  - ☐ Ticket to Work Status
  - ☐ High School Exit Document
  - ☐ Other:_____

I authorize the disclosure of this information for the following purposes:

- ☐ Determining my eligibility for services and/or determining appropriate rehabilitation services
- ☐ At my request

Dates of Services:_____

My signature indicates that I am aware of DORS policies and procedures relating to confidentiality and disclosure of records, and that I am aware that this consent can be revoked in writing at any time. My signature also means that I have read and/or had explained to me the above information and understand it. I agree that a copy of this authorization, including an electronic copy, be accepted with the same authority as the original. I understand that I may request a copy of this form.

I understand that signing this form is voluntary, but failing to sign it, or revoking it before DORS receives necessary information, could prevent a timely determination of vocational rehabilitation eligibility or appropriate vocational rehabilitation services. DORS is not a covered entity as defined by 45 CFR 160.103 and this authorization is unrelated to individual treatment, payment, enrollment in a health plan, or eligibility for health plan benefits as described in 45 CFR 164.508(c)(2).

This consent, unless revoked by me in writing, is:

- ☐ Valid for more than 45 days and continuing from date of signature while I receive rehabilitation services from DORS;
- ☐ Valid for 45 days from date of signature; or
- ☐ Expires on the following date:_____

_____ _____

Individual/Representative Signature Date

_____ _____

DORS Staff Signature Date

Information provided will become part of the DORS record of services for the individual. DORS is not a health plan or health care provider; if PHI is redisclosed by DORS, the released information may no longer be protected by the privacy provision of 45 CFR part 164 mandated by the Health Insurance Portability and Accountability Act (HIPAA), but may be protected by Maryland law. DORS, however, will only redisclose such PHI and/or other confidential information in strict accordance with applicable federal and State laws and regulations. Information which DORS believes may be harmful to the individual will be released only to the individual's representative.