Release of Information for Supporter Involvement (Non-School Related Support)

This disclosure of information is necessary to accomplish the statutory purposes of the Supported Decision-Making Act.

I, _____
(Name of Principal in a Supported Decision- Making Agreement which should accompany this release),

Authorize:

_____
(Name of Entity to release information)

To Release Information To:

_____
(Name of Supporter in a Supported Decision-Making Agreement)

For the purpose of carrying out Supporter duties under a Supported Decision-Making Agreement. Specific information to be released (list types of information to be released to the Supporter such as financial, medical or psychological information):

_____

I understand that I may revoke this consent in writing at any time and that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person/agency otherwise authorized to disclose records and communications. I Understand that the above-named person authorized to receive this information has the right to inspect and copy information to be disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations (45 CFR 160; 164). I understand that the records and communications to be disclosed may include sensitive information such as evaluations, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, sickle cell anemia and sexually transmitted diseases or HIV/AIDS unless specifically designated for exclusion:_____
It has been explained to me and I understand that my refusal to consent to this release of information will prevent information from being released and reviewed by my Supporter in a Supported Decision-Making Agreement. I understand that entities may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. This authorization is valid for 12 months following the date of signature.

_____ **_____**
(Witness Signature) **(Signature of Principal)**

_____ **_____**
(Date) **(Date)**

Standards for Privacy of Personally Identifiable Information under 45 CFR 160 and 164 state that information used or disclosed by this authorization may be subject to redisclosure by the recipient of the information. Federal Confidentiality Rules under 42 CFR 2 prohibit further disclosure of drug or alcohol information unless further disclosure is permitted by written consent of the person it pertains to or as otherwise permitted under 42 CFR 1.

GAC 7/21