Iowa Department of Health and Human Services

DDS Authorization to Disclose Information to the Iowa Department of Health and Human Services

**** Please read the entire form before signing on page 2. ****

Whose records to be disclosed:

Name (First, Middle, Last)	
SSN	Birthday (mm/dd/yy)
Parent/guardian	

This box to be completed by Disability Determination Services (as needed):

Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

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 impairments including, and not limited to:
   - Psychological, psychiatric or other mental impairments (excludes “psychotherapy notes” as defined in 45 CFR 164.501).
   - Drug abuse, alcoholism or other substance abuse.
   - Sickle cell anemia.
   - Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immuno-deficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.
   - Gene-related impairments (including genetic test results).
2. Information about how my impairments affect my ability to complete tasks and activities of daily living, and affect 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 and rehabilitation counselors
- Consulting examiners used by the Disability Determination Services Bureau

- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

To whom: The Iowa Department of Health and Human Services (HHS) and to the Disability Determination Services (DDS) authorized to process my case, including contract copy services, and doctors or other 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 Social Security Administration's 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 in which this information may be redisclosed to other parties (see page 3 for details).
- I may write to HHS and my sources to revoke this authorization at any time by completing form 470-3949, *Request to End an Authorization*.
- HHS will give me a copy of this form. 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.

Please sign using only blue or black ink:

Signature of individual authorizing disclosure

If not signed by subject of disclosure, specify basis for authority to sign: ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain):			
Additional parent/guardian/personal representative signature (not required, unless required by court order)			
Date signed	Street address		
Phone number (with area code)	City	State	Zip

Signature of witness (I know the person signing this form or am satisfied of this person's identity.)
Phone number (or address)

Signature of second witness if needed (e.g., if signed with "X" above)
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.

Explanation of Form 470-4459, DDS Authorization to Disclose Information to the Iowa Department of Health and Human Services

We need your written authorization to help get the information required to process your claim. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing form 470-4459. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few states, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to your local Department of Health and Human Services (HHS) office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. HHS can tell you if we identified any sources you didn't tell us about. HHS may use information disclosed prior to revocation to decide your claim.

It is HHS policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. HHS makes every reasonable effort to ensure that the information in form 470-4459 is provided to you in your native or preferred language.

Important Information, Including Notice Required by the Privacy Act

All personal information collected by HHS and the Disability Determination Services (DDS) is protected by the Privacy Act of 1974. Once medical information is disclosed to HHS or DDS, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA).) SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

HHS is authorized to collect the information on form 470-4599 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1), and 1631(e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the DDS processing your case and quality control people in HHS. In some cases, your information may also be reviewed by HHS personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by HHS or DDS without your consent if authorized by federal laws such as the Privacy Act and the Social Security Act. For example, HHS or DDS may disclose information:

- To assist HHS or DDS to establish rights to Social Security benefits and coverage.
- Pursuant to law authorizing the release of information from HHS records.
- For statistical research and audit activities necessary to ensure the integrity and improvement of HHS.

HHS will not redisclose without proper prior written consent information:

- Relating to alcohol or drug abuse as covered in 42 CFR part 2, or
- From educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA), or
- Regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any HHS office.