AUTHORIZATION FOR RELEASE OF INFORMATION

This box to be completed by SP/DDSD (Internal use only)

Whose records are to be disclosed:

Name—First	Middle	Last	Social security number	Date of birth (mm/dd/yyyy)

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING.

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
   - Genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living or affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological or speech evaluations, and any other records that can help evaluate function; also teacher's observations and evaluations.
4. Not only past information, but also information created within 12 months after the date this authorization is signed.

FROM WHOM:
- All medical sources (hospitals, clinics, physicians, psychologists, labs, etc.) including mental health facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by State Programs–Disability Determination Service Division (SP–DDSD)
- Employers
- Others who may know about my condition (family, neighbors, friends)

TO WHOM: The California Department of Social Services (CDSS) or the Department of Health Care Services (DHCS) for the purpose of determining whether I qualify for disability benefits, including contract copy services used to duplicate the records and doctors or other professionals consulted during the process of making the determination.

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.
- I authorize the use of a copy (including electronic copy or fax) 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 (see page 2 for details).
- Except for actions already taken, I may write to the Disability Determination Service Division and my sources to revoke this authorization at any time (see page 2 for details).
- I am entitled to a copy of this form, if I ask; I also have a right to ask the source to let me inspect or get a copy of the material to be disclosed.
- **I have read both pages of this form and agree to the disclosure above from the types of sources listed.**

INDIVIDUAL authorizing disclosure

Signature	Date	MINOR CONSENT SERVICES ONLY ☐ Yes ☐ No

If not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain relationship to subject and why the subject is unable to sign.)

NOTE: MINORS AGE 12 AND OLDER WHO COULD CONSENT TO SERVICES UNDER THE FAMILY CODE, MUST SIGN A RELEASE. ADDITIONALLY, THE PARENT OR GUARDIAN OF EVERY MINOR MUST SIGN A SEPARATE RELEASE EXCEPT IN THOSE CASES INVOLVING MINOR CONSENT ONLY. (See explanation on the reverse.)

WITNESS: I know the person signing this form or am satisfied of this person's identity: (Required for "X," illegible, or foreign character signatures)

Signature		Date	
Street address (number, street)	City	State	ZIP code

This general and special authorization to disclose information has been developed to comply with the provisions regarding disclosure of medical and other information under: The Health Insurance Portability and Accountability Act, Section 262 (a), 42 U.S. Code, Section1320d–1320d-8 (45 CFR Part 164); 42 U.S. Code, Section 290dd-2 (42 CFR part 2); 38 U.S. Code, Section 7332; 20 U.S. Code, Section 1232g (34 CFR Parts 99 and 300); and state law, including Civil Code, Section 56.10(b), Welfare and Institutions Code, Sections 10850 and 14100.2 and Civil Code, Sections 1798–1798.78.

DO NOT ALTER THIS FORM

Explanation of MC 220
AUTHORIZATION FOR RELEASE OF INFORMATION

We need your written authorization to help you get the information required to process your application for disability. Laws and regulations require that sources have an authorization before releasing information to us. Also, laws require authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form MC 220. 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. If you sign such a single authorization, we will make copies of it for each source we contact to get your information. If for any reason we need additional authorizations, we will contact you.

The reason we need minors age 12 and older to sign an authorization, in addition to the authorization signed by the parent/ guardian, is that a confidential physician-patient relationship can exist between a child and his/her doctor based on Family Code, Sections 6920–6929 under certain circumstances once the child turns 12 years of age. HIPAA authorizes disclosure in reliance on the authorization of an unemancipated minor when other provision of law allows the minor to authorize the treatment or care described in the documents to be disclosed. [45 CFR § 164.502(g)(3).] Consequently, it may be necessary to secure the child's consent in lieu of or in addition to consent by a parent in order to secure access to the needed information.

You have the right to revoke and/or modify this authorization at any time, except to the extent an action has already occurred. To do so, send a written statement to State Programs - Disability Determination Service Division (DDSD), Attn: Professional Relations Specialist. If you do, also send a copy directly to any of your sources of information that you no longer wish to disclose information about you. The California Department of Social Services can tell you if we identified any sources you did not originally tell us about. As described below, revocation or modification could result in loss of benefits.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT

All personal information collected by CDSS is protected by the Information Practices Act of 1977. In addition, information made or kept by CDSS or the DHCS in connection with the Medi-Cal program is protected by California Welfare & Institutions Code, Section 14100.2; and Title 42, United States Code (USC), Section 1396a(a)(7). Information is retained by CDSS in adherence to retention schedules prescribed by the department.

CDSS is authorized to collect the information, acting under an agreement with the DHCS, on this form under Section 14011 of the California Welfare and Institutions Code and regulations in Title 22, California Code of Regulations (CCR). The information on this form is needed to make a decision on the named applicant or beneficiary's application for, or continued eligibility for, Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application or on the continuation of benefits. Although the information obtained with this form is not typically used for any purpose other than making a determination of the applicant's disability status, such information may be disclosed by CDSS or DHCS for reasons related to the administration of the Medi-Cal Program, such as, but not necessarily limited to: (1) to enable a third party or agency to assist CDSS or DHCS in establishing rights to Medi-Cal benefits, (2) to facilitate statistical research, audit activities and fraud and abuse investigations/programs necessary to assure the integrity and improvement of the Medi-Cal Program, and (3) in administrative and related legal proceedings involving your appeal of a decision of the Medi-Cal Program. An individual has a right to access records containing his/her personal information that are maintained by CDSS. The official responsible for maintaining the information is the Deputy Director of the Disability Determination Service Division, 744 P Street, Sacramento, CA, 95814, (916) 657-2265.

ATTENTION APPLICANTS/RECIPIENTS FOR CASH ASSISTANCE PROGRAM FOR AGED, BLIND OR DISABLED IMMIGRANTS (CAPI)

In CAPI cases, in addition to the protection afforded to personal records by the Information Practices Act, as discussed above, the documents and information collected based on this authorization are subject to the protection accorded by Welfare and Institutions Code, Section 10850, et. seq., but not that provided by Welfare and Institutions Code, Section 14100.2 or other provisions applicable to the Medi-Cal Program. In general, Section 10850 forbids disclosure of lists of recipients on nonmedical public social services such as CAPI, or other identifying information or personal information for any purpose not connected with the administration of CAPI. The law authorizes the use of the records in connection with investigation, auditing, and in administrative, civil and criminal proceedings connected with CAPI program administration. The law also authorizes the sharing of such information with other public agencies for the purposes of determining eligibility for and other purposes connected with the administration of public social services, and with school officials for the purposes of administering federally assisted programs providing cash assistance or in-kind services directly to individuals based on need. Also, the law authorizes disclosure of information for research purposes, provided that information identifying the person who the records are about, is removed from the records. There is also the possibility of disclosure pursuant to an order of a court of competent jurisdiction. In reality, however, the kinds of records actually collected for the CAPI program based on this authorization are likely to be used exclusively for determining disability, except where a court orders disclosure for other purposes.