Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™
Idaho Independent Assessment Services Program
8850 W. Emerald St. – Suite 164 | Boise, ID 83704 | 208.258.7980 | FAX: 208.258.7985 |EMAIL: idahoias@libertyhealth.com

Liberty Healthcare Corporation is contracted with the Idaho Department of Health and Welfare to conduct Independent Assessments to determine eligibility for Developmental Disability Services. In order to expedite this process, please provide authorization to Liberty Healthcare Corporation to **obtain, use, and disclose** any information required to determine your eligibility for Developmental Disability Services. If you have any questions, please contact our Idaho office above.

Authorization to Obtain, Use and Disclose Health Information (to be filled out by Participant or Parent/Guardian)

PARTICIPANT INFORMATION

PARTICIPANT FULL NAME: _____ DOB: _____

ADDRESS: _____ City/State: _____ Zip Code: _____

REQUESTOR INFORMATION (To be completed if authorization is being made by someone other than the above Participant. Please provide documentation of your legal authority)

REQUESTOR NAME (if different than Participant): _____

REQUESTOR LEGAL RELATIONSHIP TO PARTICIPANT: _____

ADDRESS: _____ City/State: _____ Zip Code: _____

REQUESTOR PHONE:_____ REQUESTOR FAX: _____

I hereby authorize Liberty Healthcare Corporation to ___ **OBTAIN** from and/or ___ **DISCLOSE** (check one or both) my confidential information to/from:

To/From: _____

Address: _____ City/State: _____ Zip Code: _____

Phone Number: _____

The following information (check all the apply):

___ Schedule the Assessment ___ Physician Medical and Physical ___ Psychological Evaluation

___ Respond to Assessment ___ Independent Assessment Results ___ Neuropsychological Evaluation

___ Treatment Plan(s) ___ Medication List/Progress Note(s) ___ ASD Clinic Evaluation

___ Presence/Participation in Treatment ___ SIB-R/VABS information ___Other _____

This authorization will expire in one year unless another date or event is specified here: _____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand and certify that I may revoke this authorization at any time by notifying Liberty's HIPAA Privacy Officer in writing at the address noted above. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Information disclosed pursuant to this authorization may be subject to re-disclosure and Liberty assumes no responsibility for the use or misuse by others of my health information used, and/or disclosed under this authorization.

PARTICIPANT/LEGAL GUARDIAN (Print Name): _____Date:_____

SIGNATURE: _____

CO-LEGAL GUARDIAN (Print Name): _____Date:_____

SIGNATURE: _____