# AUTHORIZATION TO DISCLOSE INFORMATION FOR DIRECT SHIPMENT OF IN HOME SUPPORT SUPPLIES/EQUIPMENT

**Full Name: _____** **Date of Birth: _____**
(please print)

I authorize the Department of Human Services Aging, Disability and Veterans Division (ADVSD) to disclose my name, address, telephone number, and order information to a third party vendor for the purpose of fulfilling my request for in home support supplies/equipment to be shipped directly to my residence. ADVSD will not disclose anything beyond what the vendor needs to fulfill my request.

I may revoke this authorization at any time by notifying ADVSD in writing, except to the extent that action has already been taken in reliance on the authorization. This authorization will expire one (1) year from the date of signature below.

I understand that I may refuse to sign this authorization and ADVSD will make other arrangements to have my home support supplies/equipment ordered and delivered. Other delivery methods may impact delivery times. Signing this authorization is not a condition to receive treatment, payment for treatment, enrolling in a health plan or eligibility for benefits.

I am aware that once my information is disclosed, it is no longer protected and may be re-disclosed or used for another purpose by the vendor. ADVSD is not responsible for any acts by the vendor.

I may receive a copy of this authorization upon request.

►_____ _____
Signed Dated

If this authorization is signed by a person acting on behalf of another individual (eg- minor child), please complete the following, and state the authority to act on behalf of the individual.

_____ _____
Name of Personal Representative (please print) Relationship

►_____
Signature of Personal Representative