



**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize The Arc of Durham County/First In Families of Durham to disclose / receive (circle one) information about my family, including possible protected health information (PHI) to / from \_\_\_\_\_ for the purpose(s) of:

- Confirmation of eligibility for First In Families assistance
- Public awareness purposes
- At the request of the individual
- Other (specify each purpose) \_\_\_\_\_

Description or nature of information to be used and/or disclosed:

- Family member(s)' diagnosis of a developmental disability
- Services received by family member(s)
- Background information about our family
- Other: \_\_\_\_\_

**EXPIRATION**

This Authorization expires [insert date]: \_\_\_\_\_

**NOTICE OF RIGHTS AND OTHER INFORMATION**

I may refuse to sign this Authorization. Necessary services will not be conditioned on my providing or refusing to provide this authorization. I acknowledge that First In Families may be unable to provide assistance without confirmation of eligibility.

I may revoke this authorization at any time. My revocation must be in writing, signed, and delivered to the following address: The Arc of Durham County, 3500 Westgate Drive, Suite 303, Durham, NC, 27707. My revocation will be effective upon receipt, but will not be effective to the extent that The Arc of Durham County / First In Families of Durham or others have acted in reliance upon this Authorization.

I may request a copy of this Authorization.

**SIGNATURE**

Name of participant (and/or legal guardian, as appropriate):

\_\_\_\_\_ (please print)

Signature of parent (or legal guardian, as appropriate):

\_\_\_\_\_

Date Completed: \_\_\_\_\_

Received by: \_\_\_\_\_

Date: \_\_\_\_\_

The Arc of Durham County  
First In Families of Durham  
3500 Westgate Drive, Suite 303  
Durham, NC 27707  
(919)493-8141