STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED INFORMATION
CDA 9009 (REV 06/2018)

Protected information includes, but is not limited to protected health, confidential, financial, personal, or sensitive information in electronic and/or hardcopy format.

All sections must be completed for this authorization to be honored.

Employee or Program Recipient Information	
Last Name:	First Name:
Last Four Digits of Social Security Number:	
Individual/Organization to Receive the Information *The undersigned hereby authorizes CDA to release the below protected information pursuant to this authorization.*	
First & Last Name/Entity:	
Address:	
City/State/Zip:	
Phone #:	Relationship to CDA Employee or Program Recipient:
Description of Information to be Released	
Protected information for the following period of time is requested (must be completed to receive information): From: _____ (mm/dd/yyyy) To: _____ (mm/dd/yyyy)	
Description of Purpose for the Use or Release of the Information	
☐ Health Care ☐ Personal Use ☐ Legal ☐ Other (specify): _____	
Authorization Expiration Date	
Unless otherwise revoked by the employee, this authorization for the release of my protected information to the above-named individual or organization will expire on: _____ (mm/dd/yyyy). [45 C.F.R. § 164.508(c)(1)(v).]	

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Authorization Information	
I understand that: • I authorize the use or disclosure of my individually identifiable protected information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i).] • I have the right to modify or revoke this authorization by sending a signed notice modifying or stopping this authorization to the California Department of Aging. The authorization will modify or stop further release of my protected information on the date my valid modification or revocation request is received by the California Department of Aging. [45 C.F.R. §164.508(c)(2)(i) & Civ. Code § 56.15.] • I am signing this authorization voluntarily and that my treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon my authorization. [45 C.F.R. § 164.508(b)(4).] • Under California law, the recipient of the protected information under this authorization is prohibited from re-disclosing the protected information, except with a written authorization or as specifically required or permitted by law. [Civ. Code §56.13] • If the organization or person I have authorized to receive the protected information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. [45 C.F.R. §164.524(a)(2)(v).] • I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4).]	
Employee or Program Recipient Signature:	Date:
If the CDA Employee or Program Recipient is unable to sign this authorization, complete the information below	
Legal Guardian/Representative Signature:	Date:
Relationship to CDA Employee or Program Recipient:	