Client Identification

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER
		- -
ADDRESS	CITY	STATE ZIP
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION	

Washington State Department of Social & Health Services
Transforming lives

Consent

Notice to Clients: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse your benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extend allowed by law. If you have questions about how DSHS shre client confidential information or your privacy rights, please consult the DSHS Notice of Priavcy Practices or ask the person giving you this form.

Consent

1. I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments and benefits for me or other purposes authorized by law. I also grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be share verbally or electronically, by mail, or hand delivery.

   Reason for Disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.

   Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

   ☑ Social Security Administration or other federal agency: LIHEAP contractor, Hopelink
   8990 154th Ave NE, Redmond, WA 98052

   ☐ See attached list
   ☐ Other:

2. Reason for Disclosure: ___ Continuity of Care ___ Legal ___ Personal **X** Other: Financial Assistance

3. I authorize and consent to sharing the following records and information (check all that apply):
   All my client records Records on attached list
   Only the following records:
   Payment records

- This consent is valid for one year.
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared,
- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.
- A copy of this form is valid to give my permission to share records

SIGNATURE		DATE
WITNESS/NOTARY SIGNATURE IF APPLICABLE	WITNESS/NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
___ Parent ___ Legal Guardian (attach court order) ___ Personal Representative ___ Other:

Notice to Recipients of Information: **If these records contain information about HIF, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related drug or alcohol abuse by this client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.