Washington State Department of Social & Health Services
Transforming lives

Authorization

☐ I am not asking that records be disclosed at this time. Please place this authorization in my client file.

AUTHORIZATION TO DISCLOSE DSHS RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

The following information may help in locating records:	FORMER NAMES

CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE

DISCLOSE TO:

NAME LAST	FIRST	MIDDLE	TITLE

ORGANIZATION OR BUSINESS NAME IF APPLICABLE

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

REASON FOR DISCLOSURE (NOT REQUIRED)

AUTHORIZATION:

SOURCES: I authorize the following DSHS programs to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery. Check all that apply:

Behavioral Health (BHA)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC)
- ☐ Special Commitment Center (SCC)
- ☐ Forensic Mental Health Services (OFMHS)
- ☐ Other (i.e., Headquarters, RTFs):

Economic Services (ESA)
- ☐ Community Services (CSD – public assistance)
- ☐ Child Support (DCS)
- ☐ Disability Determination Services (DDDS)
- ☐ Other (i.e., Headquarters):

Office of the Secretary (OOS)
- ☐ Enterprise Risk Management (ERMO)
- ☐ Human Resources (DSHS Employee)

Aging and Long-Term Support (ALTSA)
- ☐ Home and Community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ Adult Protective Services (APS)
- ☐ Other (i.e., Headquarters):

Facilities, Finance, and Analytics (FFA)
- ☐ Background Check Central Unit (BCCU)
- ☐ Fraud and Accountability (OFA)
- ☐ Leave / Payroll (DSHS Employee)

- ☐ Developmental Disabilities (DDA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Other:

☐ All parts of the Department of Social and Health Services (DSHS)

RECORDS: I authorize the following DSHS records to be disclosed:
- ☐ Records held by parts of DSHS marked above
- ☐ Records on the attached list
- ☐ The following records only:

PLEASE NOTE: If your client or other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

SPECIAL RECORDS: I give my permission to disclose the following information held in DSHS records (check all that apply):
- ☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220)
- ☐ Mental health records (RCW 70.02.230 or 240)
- ☐ Substance Use Disorder records (42 CFR Part 2)

- This permission is valid for 180 days or ☐ until _____ (date or event, if not checked, will be 180 days).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
- I understand that my records may no longer be protected under the laws that apply to DSHS after they are produced.
- A copy of this form is valid to give my permission to disclose records. DSHS may charge to provide copies of its records.

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (AREA CODE)

PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other:

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FORM

Purpose: You should use this form when you want DSHS to be able to disclose confidential information about you to another person (including an attorney, a legislator, or a relative). You may give permission to disclose all confidential records DSHS has about you or you may limit your permission to specific records or parts of the agency. This form will also permit DSHS to discuss your situation verbally with the person you authorize.

Notice to Clients: Most client information DSHS has is confidential and will not be disclosed to others unless you grant permission or if disclosure is allowed by law. After DSHS discloses your confidential information, please be aware that the recipient may not protect your records under the same laws that apply to DSHS. DSHS cannot refuse you benefits if you do not sign this form to allow disclosures to DSHS unless your authorization is needed to determine eligibility. For information on how DSHS health care components covered by HIPAA share protected health information and your privacy rights, please consult the DSHS Notice of Privacy Practices at www.dshs.wa.gov or ask the person who gave you this form. You may get a copy of this form.

Use: You may fill out this form electronically or by hand. Use the tab key on a computer to move between fields. **A separate form must be completed for each person whose records are requested, including children.** "You" refers to the subject of the records.

Parts of Form:

IDENTIFICATION OF SUBJECT OF RECORDS:

- Name: Provide your full name or the name of the person whose records are requested if you are acting for someone else.
- Date of birth: Please include this information needed to identify you from persons with similar names.

OPTIONAL INFORMATION to help locate records:

- Former names: Include any other names that have been used when receiving benefits or services.
- Client identification number: Provide any number that DSHS may have assigned.
- Other identification number: Include any other identifier that could help locate DSHS records. Only provide a social security number if necessary.
- Date and location of services: Provide this information to help DSHS identify and locate the records you want disclosed.

PERSON RECEIVING RECORDS:

- Identification: Please fill out this section as fully as possible so we can contact the person or organization who will have access to your confidential information.
- 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.

AUTHORIZATION:

- Parts of DSHS: Please mark either the parts of DSHS you want to disclose records or mark the bottom box in this section if you want to give access to any records DSHS has about you. Write in the name of program in "Other" if not in the list.
- Information disclosed: Indicate what records that you want disclosed. You may allow disclosure of all or part of your DSHS client or other confidential records. You may also limit disclosure to client records held only by the parts of the agency marked in the section above, or to specific records listed on this form or on an attachment you sign. If there are any limitations on what records you want disclosed, either list specific records or describe the limits, such as by date of services or type of record.
- Restricted records: If any of the records may include information about HIV/AIDS or STD testing or treatment, mental health treatment, or substance use disorder services, you must check each item to allow DSHS to disclose these records. Use Psychotherapy Authorization, form DSHS 17-270, to authorize disclosure of psychotherapy notes (45 CFR 164.508(b) (3) (ii)).
- Validity: This form is valid to give access to information currently held by DSHS. Your permission expires 180 days after signature or on any other date or event you provide. If you do not provide a date, the authorization will be valid for 180 days. You may revoke the authority to release records in writing at any time but it will be too late to take back information already produced.
- Cost: The public records act in RCW 42.56.120 and WAC 388-01-080 allow DSHS to charge for copies of records plus mailing costs. State hospitals and health care facilities may charge for patient records under Chapter 70.02 RCW.

SIGNATURES:

- If you are the subject of the records, sign and also print or type your name below. Insert the date you signed plus your telephone or contact number.
- If you are signing for another person, indicate why you can do so on the last line and attach a copy of the court order or other document giving you legal authority. Children must also sign to give permission to disclose their own confidential records if they are over the age of consent (13 for mental health and drug and alcohol services; 14 for information about HIV/AIDS or other STDs; any age for birth control and abortions; 18 for health or other records).
- Witness or notary: A witness or notary may be needed to verify your identity if you do not submit this form in person or if a program requests verification. This person should sign and print his or her name.

NOTICE TO DSHS: If these records contain HIV or STD information, DSHS must notify recipients that the information is confidential and that they may not further disclose the records without a specific authorization as required by RCW 70.02.300. If DSHS sends copies of records regarding substance use disorder services under this authorization, DSHS must include the following statement when 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.