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| logo.bmp |  ECONOMIC SERVICES ADMINISTRATION (ESA) **Authorization for SSI Facilitation Records** |
| Use this form to authorize the DSHS Economic Services Administration (ESA) to provide relevant information about you to someone assisting you in the SSI facilitation process. Your request for records about your SSI application will be routed to a facilitator to provide needed information. Do not use this form to make a public records disclosure request. It will not be routed to that unit. Please use DSHS Form 17-063 when asking for records under the Public Records Act. |
| **Authorization to share records of:** |
| LAST FIRST MIDDLE | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| CLIENT ID NO. IF KNOWN | FORMER NAMES |
| **Share with:** |
| LAST FIRST MIDDLE | TITLE |
| ORGANIZATION OR BUSINESS NAME, IF APPLICABLE |
| ADDRESS CITY STATE ZIP CODE |
| TELEPHONE NUMBER (WITH AREA CODE) | FAX NUMBER | EMAIL ADDRESS |
| **I authorize DSHS to share any of the following records unless I cross them out:*** HIV/AIDS and STD test results, diagnosis or treatment records
* Mental health records
* Chemical Dependency (CD) records
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| * I may revoke or withdraw my permission in writing at any time but that will not affect information already shared.
* I understand that my records may no longer be protected under the laws that apply to DSHS after they are shared with the requestor.
* This authorization is valid for one year from the date of signing.
* My benefits or services do not depend on my signing this form.
* I have the right to a copy of this form.
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| **Authorized by:** |
| SIGNATURE DATE | TELEPHONE NUMBER (WITH AREA CODE) |
| PRINT NAME | WITNESS, IF NEEDED |
| If I am not the person who is the subject of these records, I am authorized to sign because I am (attach proof of authority): [ ]  Parent of minor [ ]  Legal Guardian [ ]  Personal Representative [ ]  Other |