

# 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 you 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 extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

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

**CONSENT:**

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 for other purposes authorized by law. I further 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 shared verbally or by computer data transfer, mail, or hand delivery.

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

Health care providers: \_\_\_\_\_

Mental health care providers: \_\_\_\_\_

Substance use disorder service providers: \_\_\_\_\_

Other DSHS contracted providers: \_\_\_\_\_

Housing programs: \_\_\_\_\_

School districts or colleges: \_\_\_\_\_

Department of Corrections: \_\_\_\_\_

Employment Security Department and its employment partners: \_\_\_\_\_

Social Security Administration or other federal agency: \_\_\_\_\_

See attached list

Other: **PEACE NW, 9414 NE Fourth Plain Road, Vancouver, WA 98662**

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

<input type="checkbox"/> Family, social and employment history	<input type="checkbox"/> Health care information	<input type="checkbox"/> Treatment or care plans
<input type="checkbox"/> Payment records	<input type="checkbox"/> Individual assessments	<input type="checkbox"/> School, education, and training
<input type="checkbox"/> Other (list): _____		

**PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.**

I give my permission to disclose the following records (check all that apply):

Mental health       HIV/AIDS and STD test results, diagnosis, or treatment       Substance Use Disorder

- This consent is valid for  one year  as long as DSHS needs records, or  until \_\_\_\_\_ (date or event).
- 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 (SIGN AND PRINT NAME, IF APPLICABLE)	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 HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the 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.

## INSTRUCTIONS FOR COMPLETION OF CONSENT FORM

**Purpose:** Use this form when you need consent to use confidential information on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law. Clients are persons receiving benefits or services from DSHS.

**Use:** Fill out this form electronically if possible for ease of reading, **A separate form must be completed for each person, including children.** “You” in the instructions refers to the DSHS employee and “you” on the form refers to the client. Sharing of records includes the use and disclosure of confidential information about a client.

### Parts of Form:

#### IDENTIFICATION:

- Name: Provide the name of one client only on each form. Include any former names that client may have used when receiving services.
- Date of Birth: Needed to identify client from persons with similar names.
- Identification Number: Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- Address and telephone: Additional information that will help in locating and identifying or contacting the client.
- Other: Include in this box any additional information that may help to locate records that may include parts of DSHS involved with services, names of family members, or other relevant information.

#### CONSENT (AUTHORIZATION):

- Agencies or persons exchanging records: The client’s completion of this form allows the use and sharing of confidential information within all of DSHS. DSHS will be able to disclose to and receive confidential information from the outside agencies or persons listed. Provide identifying information about the agencies or providers, including name, address or location if possible. You may also attach a list of agencies allowed to share information which the client must also sign.
- Information included: Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii) and a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent that serves your program purposes or as provided by law.
- Understanding: Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit

#### SIGNATURES:

- Client: Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- 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.
- Parent or Other Representative: If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark “other” and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.