



AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

Name: _____ DOB: _____

I authorize the mutual exchange of confidential information between PEACE NW HOME and the professionals or agencies listed below. A copy of this document shall be considered to be valid as the original.

(Name of Agency/Person)

(Address: Street, City, State, ZIP)

(Name of Agency/Person)

(Address: Street, City, State, ZIP)

I hereby authorize and consent to the release and/or exchange of the following confidential information relative to the above named individual: (please check)

Verbal communication regarding:

- Guardian
- Representative Payee
- Power of Attorney
- Supported Decision Making
- Developmental Disabilities Administration
- Other _____

If applicable, this confidential information is to be exchanged with: _____
(Insert Name of PEACE NW HOME Representative)

I understand that information obtained will be treated in a confidential manner by PEACE NW HOME and the responding agency/individual.

This authorization is valid from: _____ to _____.
(Date) (Date)

I understand that I do not have to sign this authorization in order to participate in PEACE NW HOME services.

Parent/Legal Guardian's Signature

Date

Printed Name

Relationship