**CONSENT FORM**

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| NOTICE TO CLIENTS: The Department of Services for the Blind (DSB) 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 DSB, and the agencies and individuals listed below to use and share confidential information about you. DSB 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, DSB may still share information about you to the extent allowed by law. If you have questions about how DSB shares client confidential information or your privacy rights, please consult the DSB Notice of Privacy Practices or ask the person giving you this form. | | | | | |
| **CLIENT IDENTIFICATION** | | | | | |
| NAME | | DATE OF BIRTH | | LAST 4 DIGIT OF SS OR ID NUMBER | |
| ADDRESS: | | TELEPHONE NUMBER (INCLUDING AREA CODE): | | FORMER NAMES(S) USED: | |
| **CONSENT:** I consent to the use of confidential information about me within DSB to plan, provide, and coordinate services, treatment, payments, or for other purposes authorized by law. I further grant permission to DSB 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 DSB and identify them by name and address: | | | | | |
| **☒** Washington Vocational Services (WVS) | | | | | |
| **☒** Selection committee (includes staff from WA State School for the Blind) | | | | | |
| Participant’s TVI: | | | | | |
| Washington State School for the Blind: **2214 E. 13th Street Vancouver, WA 98661-4120** | | | | | |
| Vocational Evaluation Information: | | | | | |
| Mental Health Care Providers: | | | | | |
| Health Care Partners: | | | | | |
| Employment Security Department and its partners: | | | | | |
| Social Security Administration or federal agency: | | | | | |
| Community Rehabilitation Providers: | | | | | |
| DSHS/DVR: | | | | | |
| Housing Programs: | | | | | |
| School Districts or Colleges: | | | | | |
| Department of Corrections: | | | | | |
| Other: | | | | | |
| 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:  Family, social and employment history  Health Care information  Individual Assessments  Payment records  Treatment or care plans  School, education, and training | | | | | | |
| 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 (RCW 70.24.105)  Chemical Dependency (CD) services (42CFR2.32) | | | | | | |
| **This consent is valid until December 31, 2024.** I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared. I understand that once the health information I authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose, at which time it may no longer be protected under privacy laws. A copy of this form is valid to give my permission to share records. | | | | | | |
| SIGNATURE | DATE | | AGENCY CONTACT/WITNESS SIGNATURE | | DATE | |
| PARENT OR OTHER REPRESENTATIVE’S SIGNATURE (IF APPLICABLE) | | | PHONE 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: | | | | | | |