

Department of
Community and Human Services
401 Fifth Avenue, Suite 500
Seattle, WA 98104
(206) 263-9100 Fax (206) 205-6565
TTY Relay 711

AUTHORIZATION TO USE AND DISCLOSE CLIENT INFORMATION

CLIENT INFORMATION

Client Name _____	**Previous Name / Alias** _____	**Client Date of Birth** _____	
Email _____	**Phone Number** _____	**Preferred Contact Method** _____	
Mailing Address _____	**City** _____	**State** _____	**ZIP Code** _____

ABOUT THIS FORM

Use this form to give KC-DCHS your permission to use or share your client information, including protected health information (PHI), with a person or organization you choose. For PHI, this authorization is governed by federal law (HIPAA) and Washington law; for other client information, DCHS applies the same standards under DCHS policy.

You do not have to sign this form. KC-DCHS will not condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. If you do not sign, KC-DCHS will not share your information except as permitted or required by law.

WHO MAY SHARE THE INFORMATION

I authorize KC-DCHS, including the division(s) I select below, to share my information as described on this form.

DIVISION(S) WHERE SERVICES WERE RECEIVED

Please check the DCHS division(s) where services were received. This helps us locate records. If you are not sure, leave this section blank or choose "Not sure."

BHRD - Behavioral Health and Recovery Division: this form cannot be used for BHRD records. Please use the BHRD release of information forms, available at https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/client-rights-privacy.

- ☐ DDECS - Developmental Disabilities and Early Childhood Supports Division
- ☐ ASD - Adult Services Division
- ☐ CYYAD - Children, Youth and Young Adult Division
- ☐ HCD - Housing and Community Development Division
- ☐ Not sure / all applicable DCHS divisions other than BHRD

WHO MAY RECEIVE THE INFORMATION

Name of person or organization: _____
Organization (if applicable): _____
Mailing address: _____
Phone: _____ Email: _____

INFORMATION TO BE SHARED

Check all that apply:

- ☐ All information in the DCHS designated record set, including payment and clinical records.
- ☐ KC-DCHS payment records.
- ☐ KC-DCHS clinical records.
- ☐ Other specific records or information (describe): _____

DATES OF SERVICE

Specify the dates of service covered by this authorization. If left blank, the authorization covers all available dates of service.

From	To
_____	_____

PURPOSE

- ☐ At my request.
- ☐ Other purpose (describe): _____

EXPIRATION

This authorization expires on the following date or event:

_____

If no date or event is specified, this authorization expires when my services with the KC-DCHS division(s) named above.

YOUR RIGHTS

You may revoke (cancel) this authorization at any time. To revoke it, write to 401 Fifth Avenue, Suite 500, Seattle, WA 98104, Attn: Privacy Officer. Your revocation will not apply to information KC-DCHS has already shared in reliance on this authorization.

Information shared under this authorization may be redisclosed by the person or organization that receives it and may no longer be protected by federal or state privacy law.

You have the right to receive a copy of this signed authorization.

WHERE TO SUBMIT THIS FORM

Mail: King County Department of Community and Human Services
401 Fifth Avenue, Suite 500

Seattle, WA 98104
Attn: Privacy Officer

Email: DCHS_Privacy@kingcounty.gov

SIGNATURE

By signing below, I certify that I am the client or the client's authorized personal representative and that the information provided on this form is accurate to the best of my knowledge.

Signature of Client or Personal Representative
_____

Date
_____

Printed Name
_____

Relationship to Client
_____

If signed by a personal representative, describe your authority to act for the client and attach supporting documentation if requested:

_____

_____

FOR INTERNAL USE ONLY (KC-DCHS STAFF)

Date received
_____

Date reviewed
_____

Request status
_____

Date communicated to client
_____

Staff person processing request
_____

_____

Request status: ☐ Accepted ☐ Denied ☐ Partially granted ☐ Clarification needed

Comments / basis for decision / follow-up needed:

_____

_____