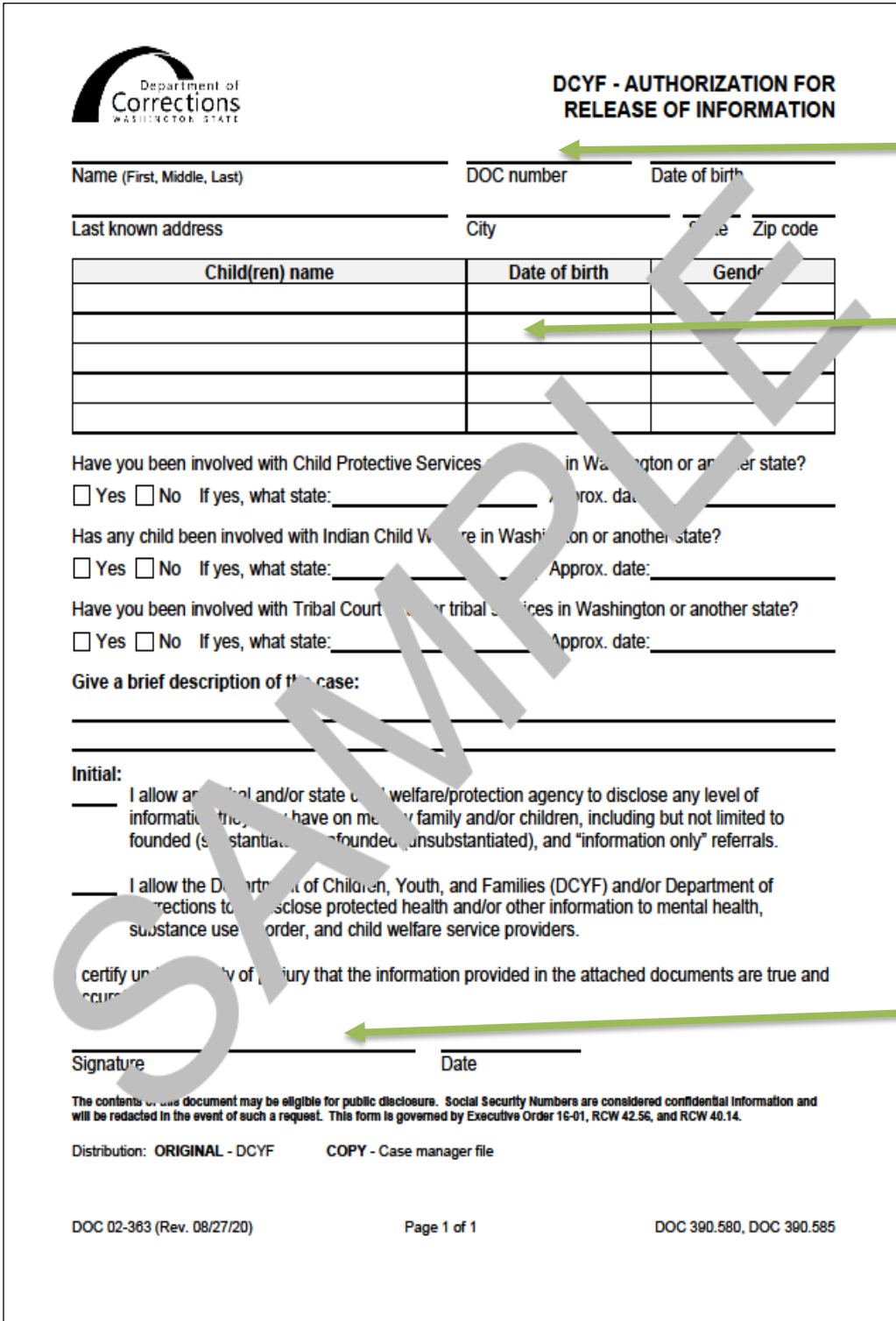


## THESE FORMS ARE FOR BOTH CPA and FOSA PROGRAMS

FORM DOC 02-363 DCYF – AUTHORIZATION FOR RELEASE OF INFORMATION



**DCYF - AUTHORIZATION FOR RELEASE OF INFORMATION**

Name (First, Middle, Last) \_\_\_\_\_ DOC number \_\_\_\_\_ Date of birth \_\_\_\_\_

Last known address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Child(ren) name	Date of birth	Gender

Have you been involved with Child Protective Services \_\_\_\_\_ in Washington or another state?  
 Yes  No If yes, what state: \_\_\_\_\_ Approx. date: \_\_\_\_\_

Has any child been involved with Indian Child Welfare in Washington or another state?  
 Yes  No If yes, what state: \_\_\_\_\_ Approx. date: \_\_\_\_\_

Have you been involved with Tribal Court \_\_\_\_\_ or tribal services in Washington or another state?  
 Yes  No If yes, what state: \_\_\_\_\_ Approx. date: \_\_\_\_\_

Give a brief description of the case:  
\_\_\_\_\_  
\_\_\_\_\_

Initial: \_\_\_\_\_

I allow an \_\_\_\_\_ and/or state child welfare/protection agency to disclose any level of information they have on me, my family and/or children, including but not limited to founded (substantiated, unfounded, unsubstantiated), and "information only" referrals.

I allow the Department of Children, Youth, and Families (DCYF) and/or Department of Corrections to disclose protected health and/or other information to mental health, substance use disorder, and child welfare service providers.

I certify under penalty of perjury that the information provided in the attached documents are true and accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: ORIGINAL - DCYF COPY - Case manager file

DOC 02-363 (Rev. 08/27/20) Page 1 of 1 DOC 390.580, DOC 390.585

This form should be filled out completely!!

Your information in this section.

Fill out the children's names completely- first, middle, and last.

Make sure you sign and date

# Filling out PSA Release of Information Forms



## FORM DCYF 14-012 Consent for Release of Information

**Consent for Release of Information**

**Notice to Clients:** By signing this form, you are giving permission for DCYF and the agencies and individuals listed below to use and share confidential information about you. DCYF 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, DCYF may still share information about you to the extent allowed by law. If you have questions about how DCYF shares client confidential information or your privacy rights, please consult the DCYF Notice of Privacy Practices or ask the person giving you this form.

**Section 1: Client Identification**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ IDENTIFICATION NUMBER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
OTHER INFORMATION: \_\_\_\_\_

**Section 2: Consent**

I consent to the use and disclosure of confidential information about me within DCYF and with those listed below to coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. Information may be shared verbally or in writing.

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

<input type="checkbox"/> Health Care Providers:
<input type="checkbox"/> Mental Health Care Providers:
<input type="checkbox"/> Substance Use Service Providers:
<input type="checkbox"/> Tribes:
<input type="checkbox"/> School Districts or Colleges:
<input type="checkbox"/> Social Security Administration or other Federal Agency:
<input type="checkbox"/> See Attached List
<input checked="" type="checkbox"/> Other (including DCYF contracted providers or other state agencies): Department of Corrections- FOSA/CPA Alternative

**I authorize and consent to sharing the following records and information (check all that apply):**

<input checked="" type="checkbox"/> All my client records	<input type="checkbox"/> Health care information	<input type="checkbox"/> Payment records
<input type="checkbox"/> Records on attached list	<input type="checkbox"/> Treatment or care plans	<input type="checkbox"/> Family, social and employment history
<input type="checkbox"/> Only the following records:	<input type="checkbox"/> Individual assets	<input type="checkbox"/> School, education and training
	<input type="checkbox"/> Other _____	

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

<input checked="" type="checkbox"/> Mental health	<input type="checkbox"/> Bloodborne pathogens test results, diagnosis, or treatment	<input checked="" type="checkbox"/> Substance Use Disorder (SUD) services
---	---	---

**Section 3: Signatures**

This consent is valid for  one year, or as long as DCYF needs records, or  until Completion of FOSA/CPA Program (date \_\_\_\_\_) or event \_\_\_\_\_.

- I may revoke or withdraw my 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 DCYF.
- A copy of this form is valid to give my permission to share records.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Agency Contact/Witness Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian or Other Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian or Other Representative's Phone Number \_\_\_\_\_ (if applicable)

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 bloodborne pathogens, 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 \_\_\_\_\_."

DCYF 14-012 (REVISED 5-2023)

**Section 1- "Client Identification"**  
Fill out as it states.  
IDENTIFICATION NUMBER is your Social Security number or DOC number.

**Section 2- "Consent"**  
The only box that needs to be marked is the last one titled "Other." You will need to put in Department of Corrections- FOSA/CPA Alternative.

Under the part that starts "I authorize and consent..." you will mark as follows- "All my client records."

**Section 3- "Signatures"** You will need to mark the box in front of "until" and in the space put- "Completion of FOSA/CPA program." Sign and date

# Filling out PSA Release of Information Forms



## FORM HCA 80-020 Authorization for Release of Information

**Authorization for Release of Information**

**1** Health Care Authority is authorized to release information or records about

Last name, First name, Middle initial \_\_\_\_\_ Client I.D. or Social Security number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone number \_\_\_\_\_

If release is for information about dependent child(ren), list name(s) of dependent child(ren) \_\_\_\_\_

**Reason/purpose for disclosure**

At the request of the individual  Other: Application for Parenting Sentencing Alternative \_\_\_\_\_

**Specific information to be used or disclosed** (including dates, if needed; attach additional pages, if more space needed) \_\_\_\_\_

**The following types of information must be specifically authorized.** This authorization includes information about the following (check all that apply):

Sexually transmitted diseases

Mental health

HIV/AIDS test results, diagnosis, or treatment

Chemical dependency treatment

**Notice to those receiving information:** If these records contain information about HIV/AIDS, sexually transmitted diseases, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission from the person and medical professional who provided the information.

This authorization will expire in 180 days from the date signed below or on (give date or event) \_\_\_\_\_

**2** Person or organization authorized to receive information or records

Department of Corrections-PSA \_\_\_\_\_ 360-725-8858 \_\_\_\_\_

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Po Box 41127 \_\_\_\_\_ Olympia \_\_\_\_\_ WA \_\_\_\_\_ 98504 \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

**3** **Signature**

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time before the expiration date or event noted above by notifying the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility and enrollment, or as allowed by law.
- The person or organization that I authorize to receive information about me or my dependent child(ren) must share it with another person or organization, and it might not be protected under the laws that apply to HCA.
- The Apple Health Notice of Privacy Practices and UMP Notice of Privacy Practices are available upon request by calling (844) 284-2149 or at [hca.wa.gov/pages/privacy.aspx](http://hca.wa.gov/pages/privacy.aspx).

**Form must be completed before signing. If signed by representative provide power of attorney or proof of guardianship.**

Signature of enrollee or enrollee's representative \_\_\_\_\_ Date \_\_\_\_\_

Signature of child (if age 13 or older) representative \_\_\_\_\_ Date \_\_\_\_\_

Printed name of enrollee's representative \_\_\_\_\_ Relationship to enrollee \_\_\_\_\_

Provide copy of power of attorney or guardian pa \_\_\_\_\_

**Section 1** - Fill out as stated.

**Under "Reason/purpose for disclosure"**  
- Mark the "other" box and write "Application for Parenting Sentencing Alternative."

**Under "The following types...."**  
- Mark all four boxes

**Under "This authorization will expire..."**  
- Write "Release from Dept of Corrections."

**Section 2** - You can just write "DOC" under NAME and nothing else needed in this section.

**Section 3** - Sign and date

# Filling out PSA Release of Information Forms



## Form DCYF 17-063 Authorization

Washington State Department of CHILDREN, YOUTH & FAMILIES				Authorization	
<b>AUTHORIZATION TO DISCLOSE DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES (DCYF) RECORDS OF:</b>					
NAME, LAST	FIRST	MIDDLE	DATE OF BIRTH		
The following information may help in locating records					
FORMER NAMES					
CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE		LOCATION OF SERVICE	
<b>DISCLOSE TO:</b>					
NAME, LAST	FIRST	MIDDLE	TITLE		
ORGANIZATION OR BUSINESS NAME IF APPLICABLE					
Department of Corrections					
ADDRESS		CITY	STATE	ZIP CODE	
PO Box 41127		Olympia	WA	98504	
TELEPHONE NUMBER (INCLUDE AREA CODE)		FAX NUMBER (INCLUDE AREA CODE)		E-MAIL ADDRESS	
360-725-8858		N/A		docpsalternative@doc1.wa.gov	
REASON FOR DISCLOSURE (NOT REQUIRED)					
Consideration of placement in the FOSA/CPA programs					
<b>AUTHORIZATION:</b>					
SOURCES: I authorize the following DCYF programs to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.					
The following programs only (check all that apply):					
<input type="checkbox"/> Juvenile Rehabilitation programs <input checked="" type="checkbox"/> All my client records <input type="checkbox"/> Other confidential records held by parts of DCYF not listed above <input type="checkbox"/> Records on the attached list <input type="checkbox"/> Personal information in employment-related records      The following records only:      Other: _____ <input checked="" type="checkbox"/> All parts of the Department of Children, Youth, and Families (DCYF)					
<b>RECORDS:</b> I authorize the following DCYF records to be disclosed:					
<input type="checkbox"/> Client records held by parts of DCYF not listed above <input checked="" type="checkbox"/> All my client records <input type="checkbox"/> Other confidential records held by parts of DCYF not listed above <input type="checkbox"/> Records on the attached list <input type="checkbox"/> Personal information in employment-related records <input type="checkbox"/> The following records only: _____					
I want to limit the records to be disclosed as follows (date, type of record, etc.):					
<b>PLEASE NOTE:</b> If you are a client of confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.					
<b>SPECIAL RECORDS:</b> I give my permission to disclose the following information held in DCYF records (check all that apply):					
<input type="checkbox"/> HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220) <input type="checkbox"/> Mental health records (RCW 70.02.230 or 240) <input type="checkbox"/> Chemical Dependency (CD) records (42 CFR Part 2)					
<ul style="list-style-type: none"> <li>This permission is valid for 180 days or <input checked="" type="checkbox"/> until <u>Completion of FOSA/CPA program</u> (date or event, if not checked, will be 180 days).</li> <li>I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.</li> <li>I understand that my records may no longer be protected under the laws that apply to DCYF after this they are produced.</li> <li>A copy of this form should be given to my permission to disclose records. DCYF may charge to provide copies of its records.</li> </ul>					
AUTHORIZED BY (SIGNATURE)		DATE SIGNED	TELEPHONE NUMBER (INCLUDE AREA CODE)		
PRINT NAME		TITLE (NECESSARY/SIGN AND PRINT NAME, IF APPLICABLE)			
If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)					
<input type="checkbox"/> Parent of minor <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative <input type="checkbox"/> Other: _____					
<b>Notice to those receiving information:</b> If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.					

Under "Authorization to Disclose Records of:"

- Please fill out your name and date of birth.

Under "Disclose To:"  
Please fill out as shown here.

Under "Authorization:"  
- Mark all the boxes as shown here.

Where it says "This permission is valid..."  
- Mark the box in front of "until" and write- "completion of CPA/FOSA program."

- Sign and date, add telephone number, and print name.

## FOSA PARTICIPANTS ONLY FOR THIS ONE

### FORM DOC 14-029 MENTAL HEALTH/CRIMINAL JUSTICE SYSTEM MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

**MENTAL HEALTH/CRIMINAL JUSTICE SYSTEM  
MULTI-PARTY AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**Consent for the release of confidential information about mental health and Substance Use Disorder (SUD) treatment.**

I, \_\_\_\_\_, authorize the Department of Corrections and the following:

Mental health treatment provider:	SUD Professional:	Provider of information necessary for cross-systems collaboration:
Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Address: _____	Address: _____	Address: _____

**to communicate with and disclose to one another the following information.** The consent must allow each type of information authorized.

Department of Corrections:	SUD treatment:
<input checked="" type="checkbox"/> Pre-Sentence Investigation	<input checked="" type="checkbox"/> Assessments and treatment plans
<input checked="" type="checkbox"/> Judgment and Sentence	<input checked="" type="checkbox"/> Treatment history and progress reports
<input checked="" type="checkbox"/> Criminal history	<input checked="" type="checkbox"/> Treatment discharge summaries
<input checked="" type="checkbox"/> Risk assessment/continuous case management tools	<input checked="" type="checkbox"/> Treatment continuing care plan
<input checked="" type="checkbox"/> Compliance with supervision	<input checked="" type="checkbox"/> Treatment compliance reports (requested by the Department)
<input checked="" type="checkbox"/> Conditions of supervision	<input checked="" type="checkbox"/> Consent to SUD Professional for an assessment
<input checked="" type="checkbox"/> Mental health assessments	<input checked="" type="checkbox"/> Involuntary treatment history/records (RCW 71.05)
<input checked="" type="checkbox"/> Violations of terms of a court ordered treatment	<input type="checkbox"/> Other:
<b>Mental health treatment:</b>	<input type="checkbox"/> Violation of a treatment order or condition of supervision related to public safety
<input checked="" type="checkbox"/> Treatment discharge summaries	<input type="checkbox"/> Information about a petition for involuntary commitment
<input checked="" type="checkbox"/> Treatment history and progress reports	
<input checked="" type="checkbox"/> Involuntary treatment history/records (RCW 71.05)	
<input checked="" type="checkbox"/> Intake and treatment plans	
<input checked="" type="checkbox"/> Psychological evaluations	
<input checked="" type="checkbox"/> Psychiatric evaluations	
<input checked="" type="checkbox"/> Forensic discharge reports (state hospital)	
<input checked="" type="checkbox"/> Treatment discharge summaries	

**The purpose of the disclosures authorized in this consent is:**

- To improve public safety by allowing communication and multidisciplinary case management and release planning.
- To enable treatment providers to communicate continuing care plan referrals to the above agencies.

I understand that this disclosure and drug treatment records are protected under the federal regulations governing the confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164.

I understand that this authorization will remain in effect for the duration of my Department supervision unless revoked prior to that time. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment, or

\_\_\_\_\_  
Specify other time when consent can be revoked and/or expires.

DOC 14-029 (Rev. 06/19/24) E-Form      Page 1 of 2      DOC 310.100, DOC 320.400, DOC 380.350, DOC 390.560, DOC 390.580, DOC 390.585

Print name here

Mark boxes like this!

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Name _____	Signature _____	Date _____
DOC number _____	Date of birth _____	Initials _____
Parent/guardian if client is under age 18 _____	Signature _____	Date _____

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2. The general rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Distribution: ORIGINAL - Imaging file      COPY - Signee


Fill out page 2 completely.

Print name, sign, and date

If you do not have a DOC number or you do not remember it, you can leave it blank.

## THESE LAST TWO ARE FOR CPA ONLY

### FORM DOC 14-172 SUBSTANCE ABUSE RECOVERY UNIT COMPOUND RELEASE OF CONFIDENTIAL INFORMATION



#### SUBSTANCE ABUSE RECOVERY UNIT COMPOUND RELEASE OF CONFIDENTIAL INFORMATION

Name: \_\_\_\_\_ DOC number: \_\_\_\_\_

Agency(s) making disclosure: Washington State Department of Corrections- Substance Abuse Recovery Unit

**TYPE OF INFORMATION TO BE DISCLOSED/REDISCLOSED**

<input checked="" type="checkbox"/> Assessment summary	<input checked="" type="checkbox"/> Discharge/transfer summary
<input type="checkbox"/> Compliance/noncompliance reports	<input checked="" type="checkbox"/> Other: <u>Verbal communication related to treatment admit, participation and discharge to include after care recommendations.</u>
<input type="checkbox"/> Treatment admission/participation/attendance status	
<input type="checkbox"/> Third-party release of assessment information, results, and treatment recommendations	

Agency \_\_\_\_\_ Date completed \_\_\_\_\_

**PURPOSE FOR USE AND/OR DISCLOSURE/REDISDISCLOSURE**

<input checked="" type="checkbox"/> Participant request	<input checked="" type="checkbox"/> Continuity of substance abuse disorder treatment
<input checked="" type="checkbox"/> Treatment compliance	<input checked="" type="checkbox"/> Legal
<input checked="" type="checkbox"/> Mutual exchange of information	<input type="checkbox"/> Other: _____

**RECIPIENT OF PROTECTED HEALTH INFORMATION**

Recipient(s), including any title, institutional class, group, or other affiliation, to disclose to or receive from (must include address, fax, and/or email address for recipient):

<input checked="" type="checkbox"/> Prison Rape Elimination Act (PREA) reporting and investigations
<input checked="" type="checkbox"/> Washington State Department of Corrections
<input checked="" type="checkbox"/> Washington State Department of Health (e.g., audits, PREA investigations)
<input checked="" type="checkbox"/> American Behavioral Health System
<input type="checkbox"/> Court: _____
<input type="checkbox"/> Judge: _____
<input type="checkbox"/> Prosecuting/Defense Attorney: _____
<input type="checkbox"/> Treatment agency: _____
<input checked="" type="checkbox"/> Other: <u>Community Parenting Alternative (CPA) Screening Committee; Washington State Department of Youth and Families; Department of Social and Human Services – Child Support Division; Department of Social and Human Services – Economic Services; Washington State Juvenile, Rehabilitation Administration.</u>

**REVOCACTION, REDISCLOSURE, DURATION**

I understand that this authorization may be revoked by me. I understand refusing to sign this agreement will result in a denial of services and will be considered failure to program, which may lead to a custody level demotion.

This consent expires automatically when there has been a formal and effective termination/revocation of my release from confinement, probation, parole, or other proceeding under which I was mandated treatment, or 60 days following discharge from treatment, or 90 days from the date of this signed consent, **whichever is later.**

I am releasing, in whole or in part, all information to a non-judicial justice entity (e.g., family member, Department of Corrections, Department of Social Health Services). I understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it or 60 days following discharge from treatment.

**AUTHORIZATION**

I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be further disclosed without my written consent unless otherwise provided for in the regulations. I have been provided a copy of this form.

Signature _____	Date of birth _____	Date _____
Employee/contract staff _____	Signature _____	Date _____

DOC 14-172 (Rev. 09/03/24)      Page 1 of 2      DOC 280.500, DOC 490.700, DOC 390.585, DOC 490.820, DOC 490.850, DOC 580.000, DOC 580.655

Fill out your name and DOC number at the top.

Under "Agency making disclosure:"  
-Add "Washington State Department of Corrections- Substance Abuse Recovery Unit"

Please mark all boxes as shown

Under "REVOCACTION, REDISCLOSURE, DURATION"  
-Initial that one line.

Under AUTHORIZATION,  
-Sign, birth date, and date.

The bottom signature should be signed and dated by your counselor or the staff member that is helping you out with the form.

# Filling out PSA Release of Information Forms



## FORM DSHS 17-063 Authorization

**Authorization**

I am not asking that records be disclosed at this time. Please place this authorization in my client file.

**AUTHORIZATION TO DISCLOSE DSHS RECORDS OF:**

NAME LAST FIRST MIDDLE DATE OF BIRTH

FORMER NAMES

The following information may help in locating records:

CLIENT IDENTIFICATION NUMBER OTHER IDENTIFICATION NUMBER DATES OF SERVICE LOCATION OF SERVICE

N/A N/A N/A N/A

**DISCLOSE TO:**

NAME LAST FIRST MIDDLE TITLE

N/A N/A

ORGANIZATION OR BUSINESS NAME IF APPLICABLE

**Department of Corrections- Parenting Sentencing Alternatives**

ADDRESS CITY STATE ZIP CODE

PO Box 41127 Olympia WA 98504

TELEPHONE NUMBER (INCLUDE AREA CODE) FAX NUMBER (INCLUDE AREA CODE) E-MAIL ADDRESS

360-725-8858 N/A DOCPSAlternative@doc1.wa.gov

REASON FOR DISCLOSURE (NOT REQUIRED)

**Consideration for placement in CPA/FOSA programs**

**AUTHORIZATION:**

SOURCES: I authorize the following DSHS programs to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transmission, mail, or hand delivery. Check all that apply:

Behavioral Health (BHA)

State Mental Health Institutions (ESH, WSH, CSTC)  Aging and Long-Term Support (TSA)

Special Commitment Center (SCC)  Home and Community Services (HCS)

Forensic Mental Health Services (OFMHS)  Residential Care Services (RCS)

Other (i.e., Headquarters, RTFs):  Adult Protective Services (APS)

Economic Services (ESA)  Other (i.e., Headquarters):

Community Services (CSD – public assistance)  Factors, Finance, and Analytics (FFA)

Child Support (DCS)  Background Check Central Unit (BCCU)

Disability Determination Services (DDDS)  Integrity and Accountability (OFA)

Other (i.e., Headquarters):  Leave / Payroll (DSHS Employee)

Office of the Secretary (OOS)  Developmental Disabilities (DDA)

Enterprise Risk Management (ERM)  Vocational Rehabilitation (DVR)

Human Resources (DSHS Employee)  Other:

All parts of the Department of Social and Health Services (DSHS)

RECORDS: I authorize the following DSHS records to be disclosed:

Records held by part of DSHS checked above  Records on the attached list

The following records only:

**PLEASE NOTE:** If your client's other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

**SPECIAL RECORDS:** I give my permission to disclose the following information held in DSHS records (check all that apply):

HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220)

Mental health records (RCW 70.02.230 or 240)

Substance abuse records (42 CFR Part 2)

• This permission is valid for 90 days or  until completion of CPA/FOSA program (date or event, if not checked, will be 90 days or more).

• I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.

• I understand that my records may no longer be protected under the laws that apply to DSHS after they are produced.

• A copy of this authorization to give my permission to disclose records. DSHS may charge to provide copies of its records.

AUTHORIZED BY (SIGNATURE) DATE SIGNED TELEPHONE NUMBER (AREA CODE)

PRINT NAME WITNESS (SIGNATURE AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

Parent of minor  Legal Guardian  Personal Representative  Other:

**Notice to those receiving information:** If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

AUTHORIZATION DSHS 17-063 (REV. 02/2024) PAGE 1 OF 2

Under "Authorization to Disclose Records of:"

- Please fill out your name and date of birth.

Under "Disclose To:"

- Please fill out as shown here.

Under "Authorization:"

- Mark all the boxes as shown here.

Under "This permission is valid..."

- Mark the box in front of "until" and write- "completion of CPA/FOSA program."

- Sign and date, add telephone number, and print name.

**HELP WITH PRINTING FORMS IS ON THE NEXT PAGE**

**IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE REACH OUT TO THE UNIT FOR HELP.**

[DOCPSAlternative@doc1.wa.gov](mailto:DOCPSAlternative@doc1.wa.gov)

## PRINTING THE ROIs- Trouble shooting

To print PDF forms correctly, always download the PDF first, open it in Adobe Acrobat Reader (not a browser), set print scaling to "**Actual Size**" or **100%**, select the correct paper size in [Page Setup](#), and use the "Print as Image" option if graphics/fonts misbehave. For alignment on pre-printed forms, test print a blank sheet with alignment marks and adjust settings, ensuring you're using dedicated PDF software for better control. **Key Settings in**

### **Adobe Acrobat/Reader**

1. **Download First:** Don't print from your browser; download the PDF to your computer.
2. **Open in Acrobat:** Use Adobe Acrobat Reader or Acrobat.
3. **Go to Print:** Press Ctrl+P (Windows) or Cmd+P (Mac), then select your printer.
4. **Page Sizing & Handling:**
  - a. Choose **Actual Size** or **100%** (not "Fit" or "Shrink").
  - b. If it's still off, try **Fit** as a second option.
5. **Page Setup:** Click **Page Setup** (or similar) to ensure the correct paper size (e.g., Letter, A4) and source are selected.
6. **Print as Image:** If content is cut off or blurry, go to **Advanced** (in the Print dialog) and select **Print as Image**.

## Troubleshooting Tips

- **Restart Devices:** Turn your printer and computer off and on again.
- **Update Drivers:** Check your printer manufacturer's website for the latest drivers.
- **Test with a Blank Page:** Print a single page to see if the issue is the file or the settings.
- **Align Pre-printed Forms:** Use alignment tools or test prints to position text correctly on existing forms.