AUTHORIZATION FORM

AUTHORIZATION TO DISCLOSE CHILD SUPPORT RECORDS OF:

LAST	FIRST	MIDDLE	DATE OF BIRTH

The following information may help in locating records		FORMER NAMES	
CLIENT IDENTIFICATION NUMBER	**OTHER IDENTIFICATION NUMBER**	**DATE OF SERVICE**	**LOCATION OF SERVICE**

DISCLOSE TO:

FIRST	LAST	MIDDLE	TITLE

ORGANIZATION OR BUSINESS IF APPLICABLE

ADDRESS	CITY	STATE	ZIP CODE

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

REASON FOR DISCLOSURE

AUTHORIZATION:

SOURCES: I authorize the following Child Support Program 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 had delivery.

☐ The following programs only (check all that apply):

- ☐ Behavioral Health and Recovery (DBHR)
- ☐ Child Support (DCS)
- ☐ Developmental Disabilities (DDD)
- ☐ Juvenile Rehabilitation Administration (JRA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Other:
- ☐ Children's Administration (CA)
- ☐ Community Services (CSD-public assistance)
- ☐ Home and community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC, SCC)

☐ All parts of the Colville Tribal Child Support Program (CTCSP)

RECORDS: I authorized the following Child Support records to be disclosed:

- ☐ Client Records held by parts of Child Support Program as marked above
- ☐ Other confidential records held by parts of Child Support marked above
- ☐ The following records only: ____________________
- ☐ All my client records
- ☐ Records on the attached List

I want to limit the records to be disclosed as follows (by date, type of record, etc):

PLEASE NOTE: If your client or 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 Child Support records (check all that apply):

- ☐ HIV/AIDS and STD test results diagnosis or treatment records (RCW 70.24.105)
- ☐ Mental Health Records (RCW 71.05.630) including:

____

- ☐ Chemical Dependency (CD) records (42 CFR Part 2) including:

- The permission is valid for 180 day or ___ until ____________________(date or event).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.
- I understand that my records may no longer be protected and the laws that apply to Child Support after this disclosure.
- A copy of the form is valid to give my permission to disclose records. Child Support may charge to provide copies of its records.

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

PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is subject of the records, I am authorized to sign because I am the (attach proof or 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.

PURPOSE: You should use this form when you want Tribal Child Support (TCSP) to be able to disclose confidential information about you to another person (including an attorney, a legislator, or a relative). You may give permission to disclose all confidential records Tribal Child Support has about you or you may limit your permission to specific records or part of the agency. This form will also permit Tribal Child to discuss your situation verbally with the person you authorize.

Notice to Clients: Most client information Tribal Child Support has is confidential and will not be disclosed to others unless you grant permission or if disclosure is allowed by law. After TCSP discloses our confidential information, please be aware that the recipient may not protect your records under the same laws that apply to TCSP. Tribal Child Support cannot refuse you benefits if you do not sign this form to allow disclosures to TCSP unless your authorization is needed to determine eligibility. For information on how TCSP shares client confidential information and your privacy rights, please consult the TCSP Notice of Privacy Practices or ask the person who gave you this form. You may get a copy of this form.

Use: A separate form must be completed for each person whose records are requested, including children. "YOU" refers to the subject of the records.

Parts of Form:

IDENTIFICATION OF SUBJECT OF RECORDS:

- **Name:** Provide your full name or the name of the person whose records are requested if you are acting for someone else.
- **Date of Birth:** Please include this information needed to identify you from persons with similar names.

OPTIONAL I NFORMATION to help locate records:

- **Former Names:** Include any other names that have been used when receiving benefits or services.
- **Client identification number:** Provide any number that Tribal Child Support may have assigned.
- **Other identification number:** Include a social security number or other identifier that could help locate Colville Tribal Child Support records.
- **Date and location of services;** Provide this information help Colville Tribal Child Support Program identify and locate the record you want disclosed.

PERSON RECEIVING RECORDS:

- **Identification:** Please fill out this section as fully as possible so we can contact the person or organization who will have access to your confidential information.
- **Reason for Disclosure:** This information is required before CTCSP can share drug and alcohol or mental health records. If you do not fill in this field CTCSP will note the reason for disclosure as being at your request.

AUTHORIZATION:

- **Parts of CTCSP:** Please mark either the parts of CTCSP you want to disclose records or mark the bottom box in this section if you want to give access to any records CTCSP has about you. Write in the name of the program in "Other" if no on the list.
- **Information disclosed:** Indicate what records that you want disclosed. You may allow disclosure of all or part of your CTCSP client records. You may also limit disclosure to client records held only by the parts of the agency marked in the section above, or to specific records listed on this form or on an attachment you sign. If there are any limitations on what records you want disclosed, either list specific records or describe the limits, such as by date of services or type of record.
- **Restricted records:** If any of the records may include information about HIV/AIDS or STD testing or treatment, mental health treatment, or drug and alcohol services, you must check each item to allow CTCSP to disclose these records. You need to complete a separate form to authorize disclosure of psychotherapy notes (45 CFR 164.508(b) (ii).
- **Validity:** This form is valid to give access to information currently held by CTCSP. Your permission expires 180 days after signature or on any other date you provide. You may revoke the authority to release records in writing at any time but it will be too late to take back information already disclosed.
- **Cost:** The public records act in RCW42.56.120 and WAC 388-01-080 allow CTCSP to charge for copies of records plus postage. State hospitals and health care facilities may impose a higher charge for patient records under Chapter 70.02 RCW.

SIGNATURES:

- **If you are the subject of the records,** sign and also print your name below. Insert the date you signed plus your telephone or contact number.
- **If you are signing for another person,** indicate why you can do so on the last line and attach a copy of the court order or other document giving you legal authority. Children must also sign to give permission to disclose their own confidential records if they are over the age of consent (13 for mental health and drug and alcohol services; 14 for information about HIV/AIDS or other STDs; any ae for birth control and abortions; 18 for health records).
- **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.

NOTICE TO CTCSP: If these records contain HIV or STD information, CTCSP must notify recipients that the information is confidential and that they may not further disclose the records without a specific authorization as required by RCW 70.2.,105(5). If CTCSP send copies of records regarding drug or alcohol services under this authorization, CTCSP must include the following statement when disclosing information as required by 42 CFT 2.32.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFT 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.