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| http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/graphics/DCYF-Logo-BW.jpg | LICENSING DIVISION (LD)  **Authorization and Consent to Share Records** | | |
| **Authorization and consent to share the records and information of:** | | | |
| NAME | | | DATE OF BIRTH |
| ADDRESS CITY STATE ZIP CODE  **, WA** | | | |
| TELEPHONE NUMBER | | ASSOCIATED WITH PROVIDER NUMBER (IF KNOWN) | |
| **Consent:** | | | |
| I consent to the Department of Children, Youth, and Families (DCYF) Licensing Division (LD), Child Placing Agency (CPA)/Group Care (CG) , and the below listed agencies, providers or persons to obtain my confidential information. I authorize LD, CPA, and the below listed agencies, providers or persons to use my confidential information and disclose it to each other for the purpose of assessing me for access to children in out-of-home care. Information may be shared verbally or by computer data transfer, mail, or hand delivery. | | | |
| **The following checked agencies, providers, or persons are included in this consent and authorization in addition to LD/CPA/GC:** | | | |
| None – I have not been asked to consent to any other agencies, providers, or persons  Amazon.com  Northwest Adoption Exchange (NWAE)  Child Placing Agency:  Health/mental health care providers:  Chemical dependency service providers:  Other: | | | |
| **The following checked records and information are included in this consent and authorization:** | | | |
| None of my client records – I have not been asked to consent  Name, address, and telephone number (for shipping)  Only the following records:  All of my client records  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  Chemical dependency  HIV/AIDS and STD test results, diagnosis, or treatment  **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 submit and meeting specific legal requirements. | | | |
| **This consent is valid for:** | | | |
| One year  Until   As long as DCYF LD/CPA needs records   * I may revoke/withdraw this consent at any time in writing, but that will not affect any information already shared. * I understand records shared under this consent may no longer be protected under the laws that apply to DCYF/CPA. * A copy of this form is valid to give my permission to share records. | | | |
| **Signatures** | | | |
| SIGNATURE | | | DATE |
| LD/CPA WORKER NAME | | | PHONE NUMBER |
| LD/CPA WORKER SIGNATURE | | | DATE |
| PARENT OR OTHER REPRESENTATIVE NAME (IF APPLICABLE) | | | |