CONSENT TO RELEASE INFORMATION

CLIENT IDENTIFICATION

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

CONSENT:

I authorize and permit Professional Registry of Nursing, Inc. (www.PRNInc.us) to use, disclose and obtain confidential information about me. This information may be used to plan, provide and coordinate services, treatment, payments and benefits for me or for other purposes allowed by law. Information may be shared in hard copy, verbally, or electronically. You may give my information to, or obtain it from, programs or persons in the classes checked below or named specifically.

☐ DSHS and other entities that administer DSHS programs.

☐ All of my health care providers or

☐ The following health care providers (list by name or type):

_____

_____

_____

☐ Chemical dependency service providers.

☐ Schools or colleges.

☐ WorkFirst partner agencies.

☐ Federal agencies.

☐ Others: _____

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

☐ All of my client records.

☐ Records on attached list.

☐ Only the following records.

☐ Family, social and employment history.

☐ Payment records.

☐ Health care information.

☐ Individual assessment.

☐ Treatment or care plans.

☐ School, education and training.

☐ Chemical dependency treatment and assessment information.

☐ Other (list): _____

You must complete this section to share the following information:

I give my permission to disclose the following records (check all that apply):

☐ Mental Health.

☐ HIV/AIDS and STD test results, diagnosis, or treatment.

☐ Chemical Dependency (CD) services.

CONDITIONS AND RIGHTS:

This consent is valid for: ☐ as long as I am receiving services, or ☐ until _____ (date or event). I may revoke or withdraw this consent at any time in writing, but that will not affect information already shared. I understand that some records shared under this consent may no long be protected under privacy lawns. A copy of this form is valid to give my permission to share records. Some information may be shared as allowed or required by law without my consent. This form has been explained to me and I can receive a copy of this form.

_____ _____

Signature: Date:

_____ _____

Parent or other representative's signature (if applicable): Date:

_____ _____

Phone: Email:

If I am not the subject of the records, I am authorized to sign because I am the:

☐ Parent

☐ Legal Guardian (attach court order)

☐ Personal representative

☐ Other: _____

Verbal Approval Information:

Date: _____ Time: _____ Phone Number Called: _____

Person Providing Authorization: _____

Mail to Address (if different from Client): _____

City: _____ State: _____ Zip: _____

Name of Scribe: _____ Signature of Scribe: _____