Disability Support Services

CONSENT FOR DISCLOSURE OF INFORMATION OR RECORDS

I, _____, do hereby authorize_____

☐ to disclose to; ☐ to obtain from; ☐ or to exchange with

Name & Affiliation	*Name & Affiliation*
Address	*Address*
City *Zip*	*City* *Zip*
	Phone

The following Information including Protected Health Information:

Purpose of and need for disclosure:

My consent shall expire in 90 days (or _____, if less than 90 days). This authorization may be revoked by me in writing at any time except to the extent that action has been taken already in response to this Consent for Disclosure of Information or Records.

I am aware that information from my record is confidential and protected by Federal and State Law. Federal and State Regulations (42 CFR Part 2 and R.C.W. 71.05, 70.02) prohibit you from making any further redisclosure of these records without my specific written consent, or as otherwise permitted by such regulations.

Client Signature *Printed Name*
Date

Witness Signature *Printed Name* *Date*