ECONOMIC SERVICES ADMINISTRATION (ESA)

Washington State Department of Social & Health Services

Authorization for SSI Facilitation Records

Use this form to authorize the DSHS Economic Services Administration (ESA) to provide relevant information about you to someone assisting you in the SSI facilitation process. Your request for records about your SSI application will be routed to a facilitator to provide needed information. Do not use this form to make a public records disclosure request. It will not be routed to that unit. Please use DSHS Form 17-063 when asking for records under the Public Records Act.

Authorization to share records of:

LAST	FIRST	MIDDLE	DATE OF BIRTH	SOCIAL SECURITY NUMBER

CLIENT ID NO. IF KNOWN	FORMER NAMES

Share with:

LAST	FIRST	MIDDLE	TITLE

ORGANIZATION OR BUSINESS NAME, IF APPLICABLE

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER	EMAIL ADDRESS

I authorize DSHS to share any of the following records unless I cross them out:

- HIV/AIDS and STD test results, diagnosis or treatment records
- Mental health records
- Chemical Dependency (CD) records

- I may revoke or withdraw my permission in writing at any time but that will not affect information already shared.
- I understand that my records may no longer be protected under the laws that apply to DSHS after they are shared with the requestor.
- This authorization is valid for one year from the date of signing.
- My benefits or services do not depend on my signing this form.
- I have the right to a copy of this form.

Authorized by:

SIGNATURE	DATE	TELEPHONE NUMBER (WITH AREA CODE)

PRINT NAME	WITNESS, IF NEEDED

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

☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other

Barcode label