Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

DDA Authorization for Release of Referral Video

Authorization for Publishing Information about:				
NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	TELPHONE NUMBER (WITH AREA CODE)
MAILING ADDRESS	CITY		STATE ZIP CODE	EMAIL ADDRESS
DDA CONTACT NAME				TELPHONE NUMBER (WITH AREA CODE)
MAILING ADDRESS	CITY		STATE ZIP CODE	EMAIL ADDRESS

Reason for release: To provide prospective community residential providers a short video of me that describes my likes, dislikes, and preferences for where I want to live and how I want to be supported in the community.

These videos may be shared within DSHS, or they may be shared with people outside of DSHS.

Description of any protected health or personal information being disclosed:

- My first name (last names will not be released)
- The fact that I receive services from DSHS DDA
- Information about the kind of disability that I have
- The type of services I receive

General description of the information being released: My likes, dislikes, interests, desires, and preferences for where I want to live and I want to be supported in the community.

DSHS cannot release any information about my status or services regarding HIV/AIDS, STDs, mental health, or alcohol or drug abuse.

Authorization for Release

I authorize the Washington State Department of Social and Health Services Developmental Disabilities Administration to share my video with community residential providers. I understand that information may be published as an unlisted video on YouTube, a non-secure public website, for _____ days.

I understand that I will not receive compensation for my participation. I also understand that I am not required to sign this authorization. If I decide not to sign, my decision will not affect any decisions about my eligibility for DSHS services or any benefits I may receive from DSHS.

- This consent is valid for ☐ one year or ☐ until _____ (date or event, not to exceed one year).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.
- A copy of this form is valid to give my permission to share information.

DSHS cannot release any information about HIV/AIDS, STDs, mental health, or chemical dependency status or services.

SIGNATURE	DATE	PRINTED NAME

If I am not the person whose information is being released, I am authorized to sign because I am the:

☐ Legal Guardian with court order in client file ☐ Durable Power of Attorney with **appropriate** authority in client file

Relationship: Telephone number (with area code):

Complete the below to revoke your authorization.

To Terminate Authorization: Complete the below information and send to the email address listed above.

I choose to revoke my authorization to release my information. I understand that revocation will not affect any previously disclosed information.

SIGNATURE	DATE	PRINTED NAME