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|  | 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 | |