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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.
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| *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 fileRelationship:  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 |