Nooksack Homeless Prevention Program • PO Box 157 • Deming, WA 98244 • 360-592-0135

Release of Information

NOTICE TO CLIENTS: The Nooksack Indian Tribe (NIT) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for NIT and the agencies and individuals listed below to use and share confidential information about you. NIT cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, NIT may still share information about you to the extent allowed by law.

CLIENT IDENTIFICATION

Name	Date of Birth	Telephone Number
Address		
Other Information:		

CONSENT

I consent to the use of the confidential information about me within the Nooksack Indian Tribe (NIT) to plan, provide, and coordinate services, treatment, payments, and benefits from other purposes authorized by law. I further grant permission to the Nooksack Indian Tribe and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail or hand delivery.
The items checked below may need to be contacted to verify eligibility.

Please indicate any additional entities in this consent in addition to NIT and identify them by name and address.

☐ MENTAL HEALTH CARE: ______________________________
☐ CHEMICAL DEPENDENCY: ______________________________
☒ OTHER DSHS PROVIDERS: ______________________________
☒ HOUSING: ______________________________
☐ EDUCATION: ______________________________
☒ EMPLOYMENT SECURITY DEPT: ______________________________
☒ TANF: ______________________________
☒ SOCIAL SECURITY ADMININSTRATION: ______________________________
☒ CHILD SUPPORT: ______________________________
☐ OTHER: ______________________________

I authorize and consent to sharing the following records & information (check that apply).

☐ All my client records ☐ Records on attached list
☐ Only the following records
☐ Family, social & employment history ☐ Health care information ☐ Treatment or care plans
☐ Payment Records ☐ Individual Assessments ☐ School, Education & Training
☐ other: ______________________________

PLEASE NOTE: If your client record includes any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records:

☐ Mental Health ☐ HIV/AIDS & STD test results, diagnosis or treatment ☐ Chemical Dependency (CD) Services

This consent is valid for: ☐ 1(one) year ☐ as long as NIT needs records, or ☐ until ________________ (date or event).

- **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 as that apply to NIT.**
- **A copy of this form is valid to give my permission to share records.**

Client Signature	Date	Agency Contact/Witness Signature	Date
Parent or Other Representative's Signature (if applicable)		Telephone Number (include area code)	Date

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐Parent ☐Legal Guardian (attach court order) ☐Personal Representative ☐Other: ____________________

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information or prosecute any alcohol or drug abuse patient.