Lower Elwha Social Services
3080 Lower Elwha Rd
Port Angeles, WA. 98363

CONSENT

NOTICE TO CLIENTS: The Lower Elwha Social Services (LESS) can help you better if we are able to work with other agencies and professionals to know you and your family. By signing this form, you are giving permission to LESS and the agencies and individuals listed below to use and share confidential information about you. LESS 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. LESS may still share information about you to the extent allowed by law.

CLIENT IDENTIFICATION:

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Other Information _____

CONSENT:

I consent to the use of confidential information about me within LESS to plan, provide, and coordinate services, treatment, payments, and benefits for me or the other purposes authorized by law. I further grant permission to LESS 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, fax, mail, or hand delivery.

Please check all below who are included in this consent in addition to LESS and identify them by name and address:

☐ Mental/Health care providers/:_____

☐ Chemical Dependency service providers: _____

☐ Housing programs: _____

☐ School Districts or colleges: _____

☐ Elwha River Casino: _____

☐ Indian Child Welfare: _____

☐ Employment Security Department and its employment partners: _____

☐ Social Security Administration or other federal agency: _____

☐ See attached list: _____

☐ Other: _____

I authorize and consent to sharing the following records and information (check all that apply):

☐ All my client records ☐ Records on attached list

☐ Only the following records: ___ Family, social and employment history ___Health care information ___Treatment or care plans ___Payment records ___Individual assessments ___School, education, and training

This consent is valid for ☐ one year ☐ as long as Lower Elwha Social Services needs the records, or ☐ until _____ (date or even).
I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
A copy of this form is valid to give my permission to share records.

Signature Date Agency Contact/Witness Signature Date

Parent or other Representative (if applicable) Telephone Number (including area code) Date