



Thurston/Mason County Developmental Disabilities Consent to Share Information



Thurston/Mason County Developmental Disabilities works with the Developmental Disabilities Administration (DDA), Division of Vocational Rehabilitation (DVR), and various local organizations to provide employment and other supportive services to adults with developmental disabilities and their family members. By signing this form, you are giving permission for the County and the agencies and individuals listed below to share information so that we can work as a team to help you achieve your goals.

Student Information

Name	Parent/Guardian	Date
Address	City	State
		Zip Code
Birthdate	Phone Number	Email

Consent/Authorization

I consent to the sharing of confidential information about me for the purpose of helping me with planning, service coordination, and resource identification. I further grant permission to Thurston/Mason County Developmental Disabilities staff and the below listed agencies, organizations, or persons to use my confidential information and disclose it to one another for these purposes. Information may be shared by computer data transfer, mail, hand delivery, or verbally.

- ☒ DSHS Divisions and Administrations including but not limited to, Developmental Disabilities Administration (DDA), Division of Vocational Rehabilitation (DVR), Children's Administration, Financial Services, Office of the Deaf and Hard of Hearing (ODHH), Department of Services for the Blind (DSB), etc.
- ☒ School District (write in): _____
- ☒ Parent/Guardian Name(s) (write in): _____
- ☒ Supported Employment Provider (select one): ☐ Centerforce ☐ EFI ☐ Morningside ☐ Vadis
- ☐ Other: _____

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

- ☒ Name, address, and phone number ☒ Information pertaining to my educational experience
- ☒ Information pertinent to training or employment ☐ Other: _____

PLEASE NOTE: If your confidential records include any of the following information you must also complete this 'Special Records' section to allow disclosure of these records.

Special Records: I give permission to disclose the following records (check all that apply):

- ☐ HIV/AIDS and STD test results, diagnosis, or treatment records (RCW 70.24.105)
- ☐ Mental health records (RCW 71.05.620) including: _____
- ☐ Chemical Dependency (CD) records (42 CFR Part 2) including: _____
- ☐ Community Protection

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may *not* further disclose that information under federal and state law without specific permission of the subject and meeting specific requirements.

This consent is valid until no longer necessary or until _____. I understand that 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 information.

Student Signature	Date
Guardian/Representative (if applicable)	
Signature _____	Print Name _____
I am the <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other _____ Date _____	

Please return this signed form to:
Thurston/Mason County Developmental Disabilities
412 Lilly Road NE
Olympia, WA 98506

Or, email or fax to:

HST.Coord@co.thurston.wa.us
Secure Fax: (833) 499-1806
Phone: (360) 867-2518