EYASSP Written Consent

Purpose: Use this form when you need consent to use confidential information on a continuing basis about a client within DCFS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law. Clients are persons receiving benefits or services from DCFS.

The client's completion of this form allows the use and sharing of confidential information within the child welfare agency. CCFS/DCFS/WCHSA will be able to disclose and receive confidential information from the outside agencies or persons listed. Provide identifying information about the agencies or providers, including name, address, or location if possible. You may also attach a list of agencies allowed to share information which the client must also sign. Fill out this form electronically, if possible, for ease of reading, **a separate form must be completed for each person, including children.**

Notice to Clients: DCFS/WCHSA/CCFS 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 The Division of Child and Family Services, Washoe County Human Services Agency, Clark County Family Services (DCFS/WCHSA/CCFS) and the agencies and individuals listed below to use and share confidential information about you (as listed below). DCFS 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, DCFS/WCHSA/CCFS may still share information about you to the extent allowed by law. If you have questions about how DCFS/WCHSA/CCFS shares client confidential information or your privacy rights, please consult with your attorney or ask the person giving you this form.

CLIENT IDENTIFICATION

NAME	DATE OF BIRTH	UNITY PERSON ID NUMBER	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

OTHER INFORMATION

CONSENT

I consent to the use of confidential information about me within DCFS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DCFS 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.
Please check all below who are included in this consent in addition to DCFS and identify them by name and address:

☐	HEALTH CARE PROVIDERS:
☐	MENTAL HEALTH CARE PROVIDERS:
☐	CHEMICAL DEPENDENCY SERVICE PROVIDERS:
☐	OTHER DCFS CONTRACTED PROVIDERS:
☐	HOUSING PROGRAMS:
☐	SCHOOL DISTRICTS OR COLLEGES:
☐	DEPARTMENT OF CORRECTIONS:
☐	EMPLOYMENT SECURITY DEPARTMENT AND ITS EMPLOYMENT PARTNERS:
☐	SOCIAL SECURITY ADMINISTRATION OR OTHER FEDERAL AGENCY:
☐	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
- ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: 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 TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.

This consent is valid while participating in the program, or until my 21st birthday.

- 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 the agency.
- A copy of this form is valid to give my permission to share records.

Signature of Applicant	Date
Signature of Agency Assigned Worker	Date
Signature of Other Representative (if applicable)	Date
Relationship of Other Representative	