GOVERNMENT OF THE DISTRICT OF COLUMBIA Child and Family Services Agency

Authorization to Access and Disclose Information

****Si usted no entiende el idioma Inglés, favor de pedir este formulario en Español**.**

Instructions

- Use this Authorization to authorize CFSA to disclose or receive information about a client (adult or child) if the information is not health related or does not concern substance abuse.
- Do not use this Authorization for the release of medical or dental information. Instead, use the "Authorization to Disclose Medical or Dental Information".
- Do not use this Authorization for the release of mental health or substance abuse information. Instead, use the "Authorization to Disclose Mental Health and Substance Abuse Information".
- If the client is Spanish-speaking and does not read English, give her or him the Spanish version of this Authorization. This form is also available in other languages upon request
- If a client is physically unable to complete the Authorization, CFSA staff may complete the Authorization under the direction of the client, as long as the client signs or marks the Authorization.
- This Authorization must be signed by someone who legally can make decisions regarding the individual who is the subject of the information. This is generally the individual if he or she is 18 years of age or older. For individuals under 18 years of age, this is generally the parent or legal guardian. **If the parent or legal guardian is not available to sign, or there are questions about who can sign, contact the Office of General Counsel.**
- Use a separate Authorization for each disclosure of information to CFSA or by CFSA

Section A: Individual who is the subject of the information		
Last Name:	First Name:	Middle Initial:
Any other name used:		
Address: *(Street Address/City/ State/Zip)*		
Telephone:		
Date of Birth: (*Month/Day/Year)*	Social Security Number:	

Section B: Authorized use or disclosure

I, _____ , authorize _____

(individual, parent, legal guardian or legal custodian) *(person or organization authorized to disclose information)*

to disclose the following information concerning the above-identified person to: _____

(person organization authorized to receive information)

Information authorized to be disclosed

(check each type of record for which release is authorized):

- ☐ Employment
- ☐ Housing (including both rental and owned properties)
- ☐ School
- ☐ Social services
- ☐ Financial, including credit information
- ☐ Motor vehicle
- ☐ Wage & earning, including information concerning unemployment benefits
- ☐ Tax returns
- ☐ Child protection clearance
- ☐ Other(s)(specify):_____

- In authorizing this disclosure, I understand that this information will be used for the purpose of: _____

_____

- I understand that this Authorization permits the release of both oral information and documents.
- I understand that the information used or disclosed on the basis of this Authorization could be disclosed again by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that I may revoke this Authorization at any time by giving my written revocation to:

D.C. Child and Family Services Agency
attn: *(insert name of social worker)*
200 I Street, SE
Washington, DC 20003

- I understand that revocation of this Authorization will *not* affect any action CFSA took in reliance of this Authorization before it received written notice of my revocation.
- I understand that this Authorization will expire 365 days from the date on which I sign it, and that I may sign a new Authorization for an additional 365 day period.
- I have received a copy of this Authorization.
- **I understand that this Authorization is voluntary.**

Section C: Signature

Signature:	If this authorization is signed by a parent, legal guardian or legal custodian, complete the following:
Print Name (*Last/First/Middle Name*):	Name printed:
Address:	Relationship to individual *(check one):* ☐ Parent ☐ Legal guardian ☐ Legal custodian
Phone number:	
Date:	

THIS AUTHORIZATION EXPIRES 365 DAYS FROM THE DATE OF EXECUTION.

Include this authorization in the individual's records and provide a copy to the individual or her/his parent, legal guardian or legal custodian.