GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

CONSENT TO OBTAIN OR RELEASE RECORD INFORMATION

□ Male
_____, □ Female born_____, residing at
Person's full name Date of birth

_____ _____ _____ _____
Address of person City State Zip Code

hereby requests that the following information:

_____

_____

be disclosed by _____
Name of person, program, and/or organization obtaining information

_____ _____ _____ _____
Address City State Zip Code

TO: _____
Name of person, program, and/or organization obtaining information
□ Parent □ Attorney □ Advocate □ Other _____

_____ _____ _____ _____
Address City State Zip Code

solely for the purpose of _____
to apply both now and in the future.

This consent will expire exactly one year from the date of signature **or** on the date specified within one year:
_____.
Date of expiration

PURSUANT TO THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978 AS AMENDED (D.C. OFFICIAL CODE § 7-1201.01 *et seq*., SPECIFICALLY § 7-1202.01), THE CITIZENS WITH INTELLECTUAL DISABILITES ACT AS AMENDED (D.C. OFFICIAL CODE § 7-1301.01 *et seq*., SPECIFICALLY § 7-1305.12), THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AS AMENDED (Pub. L. 104-191), AND OTHER LOCAL AND FEDERAL PRIVACY ACTS; I VOLUNTARILY CONSENT FOR THE DEPARTMENT ON DISABILITY SERVICES TO OBTAIN OR RELEASE RECORD INFORMATION FOR THE PURPOSE STATED ABOVE. I UNDERSTAND THAT THIS CONSENT CAN BE REVOKED BY ME IN WRITING AT ANY TIME. I UNDERSTAND THAT THIS INFORMATION MAY NOT BE REDISCLOSED WITHOUT MY PERMISSION.

SIGNED (check one): □ Person □ Legal Guardian □ Durable Power of Attorney

_____ _____ _____
Print Name Signature Date

EXPLAINED BY:_____ _____
Agency provider or representative Date

_____ _____
Title Phone number