COWLITZ INDIAN TRIBE

HEALTH & HUMAN SERVICES

Pathways to Healing Program

READ FIRST: Before you decide whether or not to let *Pathways to Healing* share some of your confidential information with another agency or person, an advocate at *Pathways to Healing* will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want *Pathways to Healing* to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that *Pathways to Healing* has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Pathways to Healing to release some of my personal information to certain individuals or agencies.

I, _____, authorize *Pathways to Healing* to share the following specific information with:
Name

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What info about me will be shared:	*(List as specifically as possible, for example: name, dates of service, and any documents).*
Why I want my info shared: (purpose)	*(List as specifically as possible, for example: to receive benefits).*

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by *Pathways to Healing*.

I understand:

☐ That I do not have to sign a release form. I do not have to allow *Pathways to Healing* to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like *Pathways to Healing* to release information about me in the future, I will need to sign another written, time-limited release.

☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from *Pathways to Healing*.

☐ That *Pathways to Healing* and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on: _____ _____
Date Time

Expiration should meet the needs of the victim, which is typically no more than 15-30 days, but may be shorter or longer.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Date: _____

Signed: _____ **Time:** _____ **Witness:**_____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____ _____
New Date New Time

Signed:_____ **Date:**_____ **Witness:**_____

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