Confederated Tribes of the Chehalis Reservation

Social Services Release of Information

CLIENT FIRST & LAST NAME	DATE OF BIRTH	PHONE NUMBER

NOTICE: Any individual 13 years of age or older must sign this Release of Information unless a legally authorized representative is signing on their behalf.

AUTHORIZATION TO RELEASE / EXCHANGE INFORMATION

I hereby authorize the release and/or exchange of information between Chehalis Tribal Social Services and the following individual(s), agency, or entity. Please check all that apply and complete names where required.

☐ Domestic Violence Advocate Name:	☐ Chehalis Tribal Court
☐ Court (Other):	☐ Legal Counselor / Attorney / Prosecutor Name:
☐ Chehalis Tribal Law Enforcement	☐ Chehalis Tribal Education Department
☐ Chehalis Tribal Enrollment Office	☐ Chehalis Tribal Housing Authority
☐ Vocational Rehabilitation	☐ Chehalis Tribal Early Learning
☐ School Name:	☐ Other:
☐ Other:	☐ Other:

RECORDS / INFORMATION AUTHORIZED FOR RELEASE

☐ All Records	☐ Specific Records Only	☐ Crime Victim / Domestic Violence Records
☐ School / Educational Records	☐ Court Records	☐ Case Notes / Reports
☐ Drug & Alcohol Records	☐ Other: _____	

SIGNATURE / AUTHORIZED REPRESENTATIVE

Signature of Client	Printed Name	Date

IF SIGNING ON BEHALF OF ANOTHER INDIVIDUAL:

Signature of Authorized Representative: _____ Relationship:

DURATION OF AUTHORIZATION

Authorization Start Date	Authorization End Date	Ongoing / Indefinite
		☐ **Yes**

CONFIDENTIALITY & REVOCATION

Please note that all information may be shared with B.C. and the CST/MDT committees. Both groups are highly confidential. This authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on it. I understand that the information disclosed may be subject to confidentiality protections.

Additional Signature (if required): _____ **Date:** _____

CONFIDENTIAL