

[APPROPRIATE AGENCY LETTERHEAD]

READ FIRST: Before you decide whether or not to let [Program/Agency Name] share some of your confidential information with another agency or person, an advocate at [Program/Agency Name] 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 [Program/Agency Name] 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 [Program/Agency Name] has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow [Program/Agency Name] to release some of my personal information to certain individuals or agencies.

I, _____, authorize [Program/Agency Name] 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 **by electronic portal**

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

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 [Program/Agency Name].

I understand:

- That I do not have to sign a release form. I do not have to allow [Program/Agency Name] 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 [Program/Agency Name] 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 [Program/Agency Name].
- That [Program/Agency Name] 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. **I understand that information sent by email may be intercepted and read by others.**

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

This release expires on _____
 Date Time

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. I understand that any information released prior to withdrawing consent is not confidential. By signing this release, I agree that [Program/Agency Name] has answered all my questions.

Signed: _____ **Date/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:** _____

Consent to Release Withdrawn on [Date/Time] _____

Orally ___ **In Writing** ___ **Received by [Staff name]** _____