



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PARENT-CHILD ASSISTANCE PROGRAM (PCAP)

University of Washington Department of Psychiatry and Behavioral Sciences

Head Researcher:

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I, _____ give permission for the UW PCAP study team to obtain
[First, Middle, Last Name]

my address and phone number to get in touch with me if there is another study in the future. I can decide later on if I want to take part or not.

I put my initials by the things I agree to:

___ I give permission for the study team to use information below to find me:

- ___ my name
- ___ my birth date
- ___ my Social Security number: _____
- ___ my tribal enrollment number: _____
- ___ family members whose names I gave to the PCAP study team at the exit interview
- ___ friends whose names I gave to the PCAP study team at the exit interview
- ___ Washington State DSHS Client Registry, ACES, and Client Services Database records

If I agree to allow the Washington State DSHS to give the UW PCAP study team my address and phone number (if available), DSHS will use their Client Registry, ACES, and the Client Services Database to find the most recent contact information for me. My address and phone number will only be used by the UW PCAP study team to find me. They will use this confidential information only to contact me directly.

I'm not required to sign this form to get any services, care, or treatment from any agency. DSHS, family or friends, if I initial above, will only give my contact information to the study team if I sign this form. I may cancel this permission at any time by calling toll free or writing to the head researcher listed above. If I cancel it, the researchers will keep information they already have.

My privacy rights are explained in the DSHS Notice of Privacy Practices for Client Medical Information (available at <https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/03-387.pdf>).

This authorization expires 6 years after the study ends, unless I cancel it before then.

PRINT FIRST, MIDDLE, LAST NAME

Signature

Date

Copies to: Participant
Researcher