



# Authorization for Release of Information

## CONTENT:

I authorize the use of a photocopy of the authorization and direct any Federal, State, or local agency organization, business, or individual to release to Tulalip Tribes Housing Department any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administering and enforcing program rules and policies.

## INFORMATION COVERED:

I understand that, depending on program policies and requirements, previous or current information regarding me or my household may be needed. Verification and inquiries that may be requested include but are not limited to:

- |                                   |                              |
|-----------------------------------|------------------------------|
| Identity and Martial Status       | Employment, Income, Assets   |
| Medical and Child Care Allowances | Credit and Criminal Activity |
| Residences and Rental Activity    | Urine Analysis Testing       |

I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for and continued participation in a housing assistance program.

## GROUP OR INDIVIDUALS THAT MAY BE ASKED:

The groups or individuals that may be asked to release the above information include but are not limited to:

- |  |                               |
|--|-------------------------------|
| Previous Employer                        | Past and Present Employers    |
| Welfare Agencies                         | Veterans Administration       |
| Courts                                   | Retirement Systems            |
| Social Security Administration           | State Unemployment Agencies   |
| Medical and Child Care Providers         | Schools and Colleges          |
| Any Tribal Entity                        | Utilities Companies           |
| Law Enforcement Agencies                 | Support and Alimony Providers |
| Central Drug and Alcohol Testing Program |                               |

## SIGNATURES:

*Every household member 18 years of age and older MUST sign. All signatures MUST be readable.*

I understand that my treatment records, if any are protected under the federal and state confidentiality regulations (42 CFR, Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA, 45 CFR, Part 164.)

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I further acknowledge that the information to be released has been fully explained to me and this consent is given of my own free will.

### Notice of Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, Part 2). The federal rules may prohibit you from making any further disclosure of this information unless expressly permitted by the written consent to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for his purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date	Head of Household	Date	Spouse
Date	18 Years and Older	Date	18 Years and Older
Date	18 Years and Older	Date	18 Years and Older