Chelan-Douglas Health District COVID-19 I&Q Release of Information

I authorize the release and receipt of information including documentation and other materials pertinent to participation in The Chelan-Douglas Health District (CDHD) Emergency Housing Program. I authorize CDHD staff to contact me via email, text, or phone regarding the Emergency Housing Program.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have applied for the COVID-19 Isolation and Quarantine (I&Q) Emergency Housing Program. If I am accepted into the program, I agree to abide by the program rules and policies. I also give permission for the CDHD staff to release and obtain information about me to the following agencies while applying and after acceptance on the program.

Please check (X) all agencies you have had contact with so CDHD can gather the documentation necessary to make an emergency housing referral:

|  |  |
| --- | --- |
|  | Community Housing Network |
|  | Chelan-Douglas Health District |
|  | Confluence Health |
|  | Cascade Medical |
|  | Chelan Hospital |
|  | CVCH |
|  | Transitional Housing Unit or Shelter (If checked, please name which one)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other: |

I agree that photocopies of this authorization may be used for the purposes stated above. This release/waiver shall be valid until revoked. If not revoked, it will remain valid for three months from your exit date from the program.

l, the undersigned, hereby release the CDHD, and all individuals connected with this organization, from any liability for acts performed in assisting and advising me in good faith. CDHD will not be liable for any personal injury or loss of property during my program participation.

By signing this release, I recognize that CDHD is an agency which is providing a service, advice and assistance to me at my request.

Furthermore, I consent to the use of confidential information about me within Chelan-Douglas Health District (CDHD) to plan, provide, and coordinate services, treatment, payments, and benefits for me to for other purposes authorized by law. I further grant permission to CDHD and the above listed agencies, providers or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer transfer, mail or hand delivery.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 7-13/2021