



## CONSENT FORM

The purpose of this form is to ask for your permission to share your confidential information and records between the WorkSource Partners and programs that provide services to you.

By giving the WorkSource Partners and programs this permission, you will make it possible for them to provide services to you without asking you to fill in another form for each program.

If you give your permission, the information and records will be shared with WorkSource Partners and programs that provide or have provided you with services, and no one else.

If you decide not to give your permission, you will still be eligible for the same programs and services, however participation in specific activities may be delayed while alternative coordination processes are utilized.

Information that could be shared includes:

- Your name
- Social security number (as an identifier and for payroll purposes, if needed)
- Address and phone number (for programs to contact you)
- Your age
- Programs enrolled in and services provided to you (current and past)
- Barriers to employment (such as health problems or transportation needs)
- Education level and needs
- Your income level and recent/current sources of income (such as wages or public assistance)
- Handicaps or physical limitations
- Other (depending on your needs and program eligibility guidelines)

***By signing this form, I hereby give the WorkSource Partners and programs permission to share my confidential records and information with each other for purposes of providing me with the services for which I am eligible, for as long as I continue to receive services, and afterwards for follow-up. I understand that the information and records shared will be kept confidential within the WorkSource Partners and programs that are providing or have provided services to me.***

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Parent or Guardian Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date