

## Permission for Release of Information "In The Event Of My Death"

*Our program will not tell anyone about the services you receive from [program] unless you specifically give us permission. Because domestic violence can result in death, we want you to know you have the right to decide what happens with your information in the event of your death. If you give us permission, we can share information about your situation and the services you received.*

I understand that signing this release is completely voluntary and will not affect my ability to receive services from [program].

In the event of my death, I authorize [program] to release information about me and my children to (please check):

Police and prosecutors

*Please be aware that information released to the police or prosecutor is not confidential. Members of the public, including news reporters, may see this information.*

Family member(s) and/or friend(s)

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

The Domestic Violence Fatality Review

*The Washington State Domestic Violence Fatality Review (DVFR) studies cases in which domestic violence results in death. The purpose of the DVFR is to help other victims and survivors by improving the community response to domestic violence.*

I do not intend for the limited release of information described above to operate as a general release. I understand I can change my mind and tell [program] in writing or verbally.

Comments:

This release expires on \_\_\_\_/\_\_\_\_/\_\_\_\_

*(If the expiration date is left blank, this release will automatically expire in 90 days. If you want this release to be indefinite, use a date 100+ years in the future, such as 1/1/2200)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Program Representative