

## Criminal Justice System/Multi-Party AUTHORIZATION FOR RELEASE OF INFORMATION

## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION ABOUT MENTAL HEALTH AND ALCOHOL OR DRUG TREATMENT

	l,	authorize (1) The Department of Corrections
Name:		
Address:	• • • • • • • • • • • • • • • • • • • •	
(4) the following Designated Chemical Dependency Specialist (OCDS): Name: Address: Phone Number: To communicate with and disclose to one another the following information (The client must initial each type of information authorized):  (1) Department of Corrections Pre-Sentence Investigation Judgment and Sentence Criminal History Risk Assessment Conditions of Supervision Conditions of Supervision Conditions of Supervision Mental Health Assessments Conditions of Terms of a Court Ordered Treatment (3) Chemical Dependency/Substance Abuse Treatment Conditions of Terms of a Court Ordered Treatment (3) Chemical Dependency/Substance Abuse Treatment Conditions of Terms of a Court Ordered Treatment (Demendency/Substance Abuse Treatment) Continuing of Terms of a Court Ordered Treatment (Plans CD Treatment Discharge Summaries — Psychological Evaluations — Psychological Evaluations — Psychological Evaluations — Psychiatric Preatment Order of Condition of Supervision that relates to Public Safety — Information about a Petition for Involuntary Commitment — (Treatment Compliance Reports (Requested by DOC) — Request to Designated Chemical Dependency Specialist (DCDS) — Treatment Compliance Reports (Requested by DOC) — Request to Designated Chemical Dependency Specialist — (DCDS) for an Assessment — Involuntary Treatment History/Records (RCW 70.96 A)  The purpose of the disclosures authorized in this consent is:  1) To improve public safety by allowing communication and multidisciplinary case management and release planning.  2) To enable treatment providers to communicate continuing care plan referrals to the above agencies  I understand that my alcohol and/or drug treatment records are plan referrals to the above agencies  I understand that my alcohol and/or drug treatment records are protected under the federal regulation		Address:
(4) the following Designated Chemical Dependency Specialist (DCDS): Name: Address: Phone Number: To communicate with and disclose to one another the following information (The client must initial each type of information authorized):  (7) Department of Corrections Pre-Sentence Investigation Judgment and Sentence Criminal History Risk Assessment Compliance with Supervision Compliance with Supervision Conditions of Supervision Mental Health Assessments Violations of Terms of a Court Ordered Treatment Chemical Dependency Assessments and Treatment Plans CD Treatment Discharge Summaries CD Treatment Discharge Summaries CD Treatment Discharge Summaries CD Treatment Discharge Summaries CD Treatment History Precords (RCW 71.05) From Social Evaluations CD Treatment Compliance Reports (Requested by DOC) Request to Designated Chemical Dependency Specialist (DCDS) CDS) for an Assessment Involuntary Treatment History/Records (RCW 70.96 A) The purpose of the disclosures authorized in this consent is: (I) To mnove public selete by allowing communication and mulidisciplinary case management and release planning. (2) To enable treatment providers to communication and mulidisciplinary case management and release planning. (2) To enable treatment providers to communicate continuing care plan referrals to the above agencies  Lunderstand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and form by CC supervision unless revoked prior to that time. I also understand that in authorization shall entire in effect for the duration of my DOC supervision unless revoked prior to that time. I also understand that this authorization shall rain in effect for the duration of my DOC supervision unless revoked prior to that time. I also understand that the surface of the duration of my DOC supervision unless revoked prior to that time. I also understand that		
Address:	Thore Number.	Thore Number
Address:	• •	(5) the following <u>other provider of information</u> necessary for cross-systems communication:
To communicate with and disclose to one another the following information (The client must initial each type of information authorized):  (1) Department of Corrections Pre-Sentence Investigation Judgment and Sentence Criminal History Risk Assessment Compliance with Supervision Conditions of Supervision Mental Health Assessment Violations of Terms of a Court Ordered Treatment Chemical Dependency Assessments and Treatment Plans C D Treatment History and Progress Reports Psychiatric Evaluations Pre-Source Agriculture of the Mischarge Summaries C D Treatment Discharge Summaries C D Treatment History Agriculture of the Mischarge Summaries C D Treatment Continuing Care Plan C D Treatment Continuing Care Plan C D Treatment Commining Reports (Requested by DCC) Request to Designated Chemical Dependency Specialist (DCDS) for an Assessment Involuntary Treatment History/Records (RCW 70.96 A) The purpose of the disclosures authorized in this consent is:  (1) To improve public safety by allowing communication and multidisciplinary case management and release planning.  (2) To enable treatment providers to communicate continuing care plan referrels to the above agencies  I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Accountability Act of 1998 (HIPAA), 45 CFR, Parts 160 and 164. I understand that this authorization shall remain in effect for the duration of my DOC supervision unless revoked prior to that time. I also understand that this authorization shall remain in effect for the duration of my DOC supervision unless revoked prior to that time. I also understand that I may revoke this consent any time except to the extern that action has been taken in reliance on it, and that in any event this consent to a disclosure for purposes of treatment, providers to consent can be revoked and/or expires)  I understand that I might be denied services if I refuse to consent to a disclosure for other purposes.  Signature of Offender/Client:  Interest He		Name:
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Treatment Compliance Reports (Requested by DOC) Request to Designated Chemical Dependency Specialist (DCDS) for an Assessment Involuntary Treatment History/Records (RCW 70.96 A)  The purpose of the disclosures authorized in this consent is:  (1) To improve public safety by allowing communication and multidisciplinary case management and release planning.  (2) To enable treatment providers to communicate continuing care plan referrals to the above agencies  I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164. I understand that this authorization shall remain in effect for the duratior of my DOC supervision unless revoked prior to that time. 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, and that in any event this consent expires automatically as follows:  There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment, or,  (Specify other time when consent can be revoked and/or expires)  I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.  Signature of Offender/Client:  Initials:  Date:	CD Treatment Discharge Summaries	
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The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2 and 45 CFR Parts 160 and 164. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person 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 this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.