SPOKANE REGIONAL
MENTAL HEALTH COURT ROI

PO Box 2352
721 North Jefferson St, Suite 200
Spokane, Washington 99260-2352

Phone: (509) 477-2230
Fax: (509) 477-2231
Email: dctherapeuticcourts@spokanecounty.org

AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Defendant's Name: _____ Date of birth: _____

Defendant Email: _____ OK to leave detailed messages? _____

Defendant Phone: _____ OK to leave detailed messages? _____

I request and authorize the following agencies:

☐ ABHS
☐ Beyond Behavioral Health
☐ CAReS
☐ CHAS Clinic
☐ Deaconess Medical Center
☐ Eastern State Hospital
☐ Frontier Behavioral Health
☐ Inland Northwest Behavioral Health
☐ New Horizons
☐ Pioneer Human Services
☐ Sacred Heart Medical Center
☐ SPARC
☐ Spokane County Jail (Mental Health Unit)
☐ STARS
☐ Veteran's Administration
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____

To release and exchange the healthcare information of the patient named above to the Spokane Regional Mental Health Court Team:

Spokane Regional Mental Health Case Management Team
Spokane Municipal/District Court Prosecutor
Spokane Municipal/District Court Public Defender
Spokane Municipal Community Justice Services
Spokane County District Court Probation
Private Attorney
Beyond Behavioral Health Staff
New Horizons Staff

This request and authorization document applies to:
☑ Medical Diagnosis and Treatment ☑ Alcohol and Drug Abuse Treatment ☑ All mental health information: treatment plans, intake evaluations, medications, relevant progress reports, etc.

The above information will be used for the purpose of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring for compliance with a treatment program, including informing the court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis, and completion of treatment. I understand I do not have to sign this authorization. I understand that at any time I may revoke this authorization; however, the revocation must be in writing with the participant's signature and sent to 721 N. Jefferson St, Suite 200, Spokane, WA 99260. I understand that if I do not revoke this authorization, it will expire in five years. I understand the recipient of the above-requested information may re-disclose it, at which time it may no longer be protected under privacy laws.

THIS SECTION MUST BE COMPLETED BY DEFENDANT:

I understand that my records may be confidential, depending on the information contained in them, under one or more of the following statutes or regulations: Medical Records (including mental health records), RCW 70.02; Drug or Alcohol Treatment Records, RCW 70.96A.150 and/or Code of Federal Regulations, Title 42, volume 1, Part 2 and/or Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these tests results to anyone.

☐ YES I authorize the release of my alcohol and/or drug test results, whether negative or positive, to the person(s) listed above.

☐ YES I authorize the release of any records regarding drug, alcohol, hospitalization, counseling, evaluations, medical, progress reports or mental health treatment to the person(s) listed above.

Signature: _____ Date Signed: _____