Spokane County Courthouse

SPOKANE COUNTY DISTRICT/ COURT
Veteran's Court Team
Broadway Centre
P.O. Box 2352
721 North Jefferson
Spokane, Washington 99210-2352
Phone: (509) 477-2230 Fax: (509) 477-2231

AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________________

Previous Name: ______________________________ Social Security #: ____________________

I request and authorize the following agencies:

- ☐ Behavioral Assessment Counseling
- ☐ Carlyle House
- ☐ Catholic Charities
- ☐ CHAS Clinic
- ☐ Christ Clinic
- ☐ Deaconess Medical Center
- ☐ Doctor's Clinic
- ☐ Eastern State Hospital
- ☐ Family Service Spokane
- ☐ Grande Manor
- ☐ Hilltop Center
- ☐ Lutheran Community Services NW
- ☐ Mallon Place
- ☐ Memory Lane
- ☐ Northwest Behavioral Health Center
- ☐ Phoenix Apartments
- ☐ Sacred Heart Medical Center
- ☒ Spokane County Jail (Mental Health Unit)
- ☒ Spokane County RSN
- ☐ Spokane County Supportive Living
- ☐ Spokane County Triage
- ☐ Spokane Falls Family Clinic
- ☐ Spokane Mental Health
- ☐ Sunshine House
- ☐ Valley View
- ☒ Department of Veterans Affairs__________
- ☐ Other: ______________________________
- ☐ Other: ______________________________
- ☐ Other: ______________________________
- ☐ Other: ______________________________

to release and exchange the healthcare information of the patient named above to the Veteran's Court Team:

Spokane County Veteran's Court Team
Spokane County Prosecutor
Spokane County Public Defender
Spokane County Probation

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

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. I understand the recipient of the above-requested information may re-disclose it, at which time it may no longer be protected under the privacy laws.

THIS SECTION MUST BE COMPLETED BY PATIENT:

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, 38 U.S.C. 7332. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date Signed: ______________________________

THIS AUTHORIZATION EXPIRES ON ____________________.

Note: This authorization may be photocopied for duplication as necessary for the use in gathering additional information.