SPOKANE REGIONAL MENTAL HEALTH COURT

P.O. Box 2352
721 North Jefferson, Suite 200
Spokane, Washington 99260-2352
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/ FBH
- ☐ Lutheran Community Services NW
- ☐ Northwest Behavioral Health Center
- ☐ Sacred Heart Medical Center
- ☐ SPARC
- ☐ Spokane County Jail (Mental Health Unit)
- ☐ Spokane County RSN
- ☐ Better Health Together/Consistent Care Program
- ☐ Spokane County Triage
- ☐ Spokane Falls Family Clinic
- ☐ Spokane Mental Health/ Frontier Behavior Health
- ☐ Sunshine Terrace
- ☐ Veterans Administration Medical Center: Team Color__________
- ☐ YFA
- ☐ New Horizons
- ☐ Other: ____
- ☐ Other: ____
- ☐ Other: ____

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

Spokane County Mental Health Court Team
Spokane City/County Prosecutor
Spokane City/County Public Defender
City/County Probation

PO Box 2352
Spokane, WA 99260-2352
Phone: (509) 477-2230
Fax: (509) 477-2231

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: send to 721 N. Jefferson Suite 200, Spokane WA 99260. 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. 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, hospitalization, counseling, evaluations, medical, progress reports or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date Signed: ______________________________

THIS AUTHORIZATION EXPIRES UPON THE END OF MENTAL HEALTH COURT JURISDICTION (this includes probationary period).
Note: This authorization may be photocopied for duplication as necessary for the use in gathering additional information.