# CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, (Name of client or Person giving consent & relationship to Client) hereby authorize _____, (Individual and Agency should be noted) to release/exchange information specified below to Pierce County District Court Probation.

## TYPE OF INFORMATION TO BE RELEASED

Client must initial all applicable items:

| Date | Initials | |
|---|---|---|
| _____ | ____ | Mental Health diagnosis, treatment recommendations and prognosis. |
| _____ | ____ | Batterers/Substance abuse evaluation, diagnosis, treatment recommendation and prognosis. |
| _____ | ____ | Legal/social treatment history records. |
| _____ | ____ | General progress report information. |
| _____ | ____ | Medical & medication information related to past & present records; diagnosis and prognosis for client. |
| _____ | ____ | Drug and alcohol testing services and treatment records |

*The above information is released for the following purpose(s):*

| | | |
|---|---|---|
| _____ | ____ | Assist parole or probation officer, defense attorney and/or courts in both oral and written reports concerning treatment status, plans and/or progress. |
| _____ | ____ | Assist other agencies in determination of appropriateness of possible treatment placement. |
| _____ | ____ | To monitor compliance with the conditions of the court ordered probation, deferred prosecution, or conditional release. |

I understand that my medical records, including alcohol and/or drug treatment records, may be protected under Federal and State Law (42 CFR Part 2 and RCW 70.24) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA"), 45 CFR parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Once disclosed, the recipient may not be required to maintain the confidentiality of the health care information. However, I understand that certain health care information may be protected. I understand that my medical care (treatment, payment, or enrollment) is not conditioned on my signing this authorization, but that my court ordered probation may be revoked.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT MY CONSENT HAS BEEN RELIED UPON. I ALSO UNDERSTAND THAT REVOCATION OF THIS CONSENT MAY PUT ME IN BREACH (VIOLATION) OF MY CONDITIONS OF PROBATION. I UNDERSTAND THAT IF I REVOKE THIS CONSENT IN WRITING AT ANY TIME PRIOR TO THE FINAL DISPOSITION OF MY DEFERRED PROSECUTION, PROBATION, OR CONDITIONAL RELEASE, MY CASE MAY BE RETURNED TO THE COURT FOR FURTHER PROCEEDINGS.

THIS CONSENT WILL EXPIRE ON _____

_____ _____
Client's signature Date

_____ _____
Probation Officer/Witness signature Date

_____
Probation Officer/Witness Name

RESTRICTION ON REDISCLOSURE AND USE: UNDER FEDERAL LAW (42CFR §2.35 and 45CFR Parts 160 and 164), A PERSON WHO RECEIVES PATIENT INFORMATION PURSUANT TO THIS CONSENT MAY REDISCLOSE IT ONLY TO CARRY OUT THAT PERSON'S OFFICIAL DUTIES WITH REGARD TO THE DEFERRED PROSECUTION, PROBATION, OTHER CONDITIONAL RELEASE, OR OTHER ACTION OR PROCEEDING IN CONNECTION WITH WHICH THE CONSENT WAS GIVEN.