CLARK COUNTY DISTRICT COURT – Therapeutic Specialty Courts
Consent for the Release of Confidential Information

I, _____ _____
Name of Participant ***Date of Birth***

_____
Participant Address/Phone

Hereby consent to communication between:

(please initial)

_____ **Sea Mar - CSNW Vancouver, WA**

_____ **Lifeline Connections Vancouver, WA**

_____ **Clark County Prosecutor's Office Vancouver, WA**

_____ **City of Vancouver Attorney's Office Vancouver, WA**

_____ **Clark County WA District Court/Probation**

_____ **Clark County CVAB / REACH Too**

_____ **Drug Testing (Cordant & Redwood Lab)**

_____ **Connectrex Data Systems**

_____ **Automon/AIMS Data Systems**

_____ **Clark County Indigent Defense Counsel**

_____ **Clark County Sheriff's Office**

(please initial)

_____ **Columbia River Mental Health Services**

_____ **Other treatment:** _____

_____ **National Center for State Courts - Eval**

_____ **Court evaluation team -** _____

_____ **A Better Way Counseling (DV treatment)**

_____ **Department of Social & Health Services**

_____ **Department of Veterans Affairs**

_____ **WA Department of Veterans Affairs**

_____ **WA State Department of Corrections**

_____ **Clark County Dept. of Community Services**

_____ _____
(Other/family/friend/employer/school)

_____ _____
(Other/physician/psychiatrist)

AND THE
CLARK COUNTY DISTRICT COURT – THERAPEUTIC SPECIALTY COURTS

☐ **SAC/DUI Team** (Judge, JA/Clerk, PA, DA, JA/Clerk, CA, Coordinator, Tx Case Manager, PO &/or designees, evaluator)

☐ **MHC Team (**Judge, JA/ Clerk, PA, DA, CA, Coordinator, Tx Case Manager, PO &/or designees, evaluator)

☐ **VETCO Team** (Judge, PA, DA, CA, Coordinator, VA, WVA, Tx Case Manager, PO &/or designees, evaluator)

I understand that my medical, mental health, and substance abuse records are protected under the federal regulations governing confidentiality of health information, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 Code of Federal Regulations (CFR), Parts 160 and 164, 42 CFR Part 2, RCW chapters 70.02, 70.24, 70.28, 70.96A, 71.05 and 71.34, and cannot be disclosed without my written authorization unless otherwise provided for in the statutes and regulations. I also understand that I may revoke this authorization 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:

(please initial)

_____ **there has been a formal and effective completion / termination or revocation of my release from the THERAPEUTIC SPECIALTY COURT Program plus an additional 45 days beyond program end but not to exceed three years from the date of this release.**

I further understand that some or all of this information will be discussed in open court, where any person in the courtroom may hear the information. The nature of the information to be shared will include, but is not limited to: arrest and prior criminal record, police report, intake, risk and alcohol/drug use, mental health assessment and diagnosis information, treatment plans, court directives, drug test results, progress reports, reports of program compliance and other related behavior, and recommendations for services, sanctions, and rewards.

_____ _____
Dated: **Signature of Participant**

_____ _____
Dated: **Authorized Program Representative**