Department of Corrections
WASHINGTON STATE

ATTORNEY REPRESENTATION
CONSENT FOR RELEASE OF INFORMATION

Name	DOC number	Hearing date with attorney
Attorney (if known)	Phone number	Email

I authorize the Department of Corrections to communicate with and disclose to the attorney, who will represent me at my hearing, information and records concerning the following (check all that apply):

- ☐ Any total/partial confinement term served with the Washington State Department of Corrections
- ☐ Any term of supervision served with the Washington State Department of Corrections
- ☐ Mental health treatment received while serving a term with the Washington State Department of Corrections
- ☐ Substance use disorder treatment received while serving a term with the Washington State Department of Corrections
- ☐ Sex offense treatment received while serving a term with the Washington State Department of Corrections
- ☐ Criminal history record information

The disclosures authorized in this consent will allow the Department of Corrections to provide pre-hearing discovery to my attorney, upon request. I understand discovery materials may be limited to materials that are relevant to the violations alleged by the Department of Corrections.

I understand that:

My alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Heath Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 and 164.

This authorization will remain in effect for the duration of this specific hearing process, to conclude upon the completion of the hearing or upon a decision by the Department not to conduct the hearing.

My attorney may not receive all requested discovery information and records if I refuse to consent. I will not be denied my right to a hearing or my right to an attorney, if applicable, if I refuse to consent to disclosure.

I have a right to revoke this authorization of release at any time in writing. I understand that later revocation will not apply to information already provided under this release.

Name	Signature	Date
Witness	Signature	Date

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

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