



SUBSTANCE ABUSE RECOVERY UNIT COMPOUND RELEASE OF CONFIDENTIAL INFORMATION

Name: _____ DOC number: _____

Agency(s) making disclosure: _____

TYPE OF INFORMATION TO BE DISCLOSED/REDISCLOSED

- Assessment summary
- Compliance/noncompliance reports
- Treatment admission/participation/attendance status
- Third-party release of assessment information, results, and treatment recommendations:
- Discharge/transfer summary
- Other: _____

Agency _____

Date completed _____

PURPOSE FOR USE AND/OR DISCLOSURE/REDISCLASURE

- Participant request
- Treatment compliance
- Mutual exchange of information
- Continuity of substance use disorder treatment
- Legal
- Other: _____

RECIPIENT OF PROTECTED HEALTH INFORMATION

Recipient(s), including any title, institutional class, group, or other affiliation, to disclose to or receive from (***must include address, fax, and/or email address for recipient***):

- Prison Rape Elimination Act (PREA) reporting and investigations
- Washington State Department of Corrections
- Washington State Department of Health (e.g., audits, PREA investigations)
- Court: _____
- Judge: _____
- Prosecuting Attorney: _____
- Defense Attorney: _____
- Treatment agency: _____
- Other: _____

REVOCATION, REDISCLASURE, DURATION

I understand that this authorization cannot be revoked by me. I understand refusing to sign this agreement will result in a denial of services and will be considered failure to program, which may lead to a custody level demotion.

This consent expires automatically when there has been a formal and effective termination/revocation of my release from confinement, probation, parole, or other proceeding under which I was mandated treatment, **or** 60 days following discharge from treatment, **or** 90 days from the date of this signed consent, **whichever is later**.

_____ If I am requesting release of information to a non-criminal justice entity (e.g., family member, Department of Licensing, Department of Social Health Services). I understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it **or** 60 days following discharge from treatment.

AUTHORIZATION

I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be further disclosed without my written consent unless otherwise provided for in the regulations. I have been provided a copy of this form.

Signature

Date of birth

Date

Employee/contract staff

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.

Distribution: **ORIGINAL** - Clinical file **COPY** - Participant