



## SPOKANE COUNTY DUI THERAPEUTIC COURT ROI

PO Box 2352  
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Spokane, Washington 99262352

Phone: (509) 477-2230  
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Email: [dctherapeuticcourts@spokanecounty.org](mailto:dctherapeuticcourts@spokanecounty.org)

### AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Defendant's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Defendant Email: \_\_\_\_\_ OK to leave detailed messages? \_\_\_\_\_

Defendant Phone: \_\_\_\_\_ OK to leave detailed messages? \_\_\_\_\_

*I request and authorize the following agencies:*

- |   |   |
|---|---|
| <input type="checkbox"/> ABHS                               | <input type="checkbox"/> Sacred Heart Medical Center              |
| <input type="checkbox"/> Beyond Behavioral Health           | <input type="checkbox"/> SPARC                                    |
| <input type="checkbox"/> CARES                              | <input type="checkbox"/> Spokane County Jail (Mental Health Unit) |
| <input type="checkbox"/> CHAS Clinic                        | <input type="checkbox"/> STARS                                    |
| <input type="checkbox"/> Deaconess Medical Center           | <input type="checkbox"/> Veteran's Administration                 |
| <input type="checkbox"/> Eastern State Hospital             | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Frontier Behavioral Health         | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Inland Northwest Behavioral Health | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> New Horizons                       | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Pioneer Human Services             |   |

*To release and exchange the healthcare information of the patient named above to the Spokane County DUI Therapeutic Court team:*

**Therapeutic Courts Case Management Team**  
**Spokane District Court Prosecutor**  
**Spokane District Court Public Defender**  
**New Horizons Staff**

**Spokane County District Court Probation**  
**Private Attorney**  
**Beyond Behavioral Health Staff**

**This request and authorization document applies to:**

☒ Medical Diagnosis and Treatment   ☒ Alcohol and Drug Abuse Treatment   ☒ All mental health information: treatment plans, intake evaluations, medications, relevant progress reports, etc.

*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 with the participant's signature and sent to 721 N. Jefferson St, Suite 200, Spokane, WA 99260. I understand that if I do not revoke this authorization, it will expire in five years. I understand the recipient of the above-requested information may re-disclose it, at which time it may no longer be protected under privacy laws.*

#### THIS SECTION MUST BE COMPLETED BY DEFENDANT:

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 tests results to anyone.

☐ YES I authorize the release of my alcohol and/or drug test results, whether negative or positive, to the person(s) listed above.

☐ YES 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.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_