

**SKAGIT COUNTY MENTAL HEALTH COURT**  
**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**  
**FOR ELIGIBILITY AND SUITABILITY**

I, \_\_\_\_\_, DOB \_\_\_\_\_ authorize (initial whichever parties apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Skagit County Superior Court                     | <input type="checkbox"/> Department of Corrections _____ |
| <input type="checkbox"/> Skagit County Public Defender                    | <input type="checkbox"/> Sunrise Services                |
| ____ Defense Counsel: _____   | ____ Sea Mar _____                                       |
| <input type="checkbox"/> Skagit County Prosecuting Attorney               | ____ Skagit Recovery _____                               |
| ____ Municipal Court Prosecuting Attorney                                 | <input type="checkbox"/> Phoenix Recovery _____          |
| <input type="checkbox"/> Skagit County Public Health & Community Services | ____ Pioneer Center North _____                          |
| <input type="checkbox"/> Skagit County Sheriff                            | ____ Inslee Maxwell                                      |
| <input type="checkbox"/> Skagit County Jail Health Services               | ____ Other _____   |
| ____ Compass Health   |  |

to communicate with and disclose to one another the following information (nature and amount of information to be as limited as possible):

- |  |  |
|--|--|
| <input type="checkbox"/> Mental Health Diagnosis and Treatment | <input type="checkbox"/> Criminal History, Sentencing, Probation |
| <input type="checkbox"/> Alcohol and Drug Abuse Treatment      | ____ Other _____   |
| <input type="checkbox"/> Medical Diagnosis and Treatment       | ____ Other _____   |

The purpose of this disclosure is to determine my eligibility for Skagit County Mental Health Court program.

I understand that some of the information contained in these files is confidential, and I agree to allow access to those files for this purpose. 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 CFR Part 2, and 45 CFR Parts 160 and 164 (HIPAA), governing protected health information, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Health information that may be used or disclosed through this Authorization is as follows (initial which applies):

All Health information about me, including my clinical records, created or received by the Provider. This information may include, if applicable: information pertaining to the identity, diagnosis, prognosis or treatment for psychiatric disorders/mental health, HIV/AIDS virus or sexually transmitted diseases and/or alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse programs; or

\_\_\_\_ Specific health information including only: \_\_\_\_\_

I have read and understand the terms of this Authorization and it is given of my own free will. I also understand that I may revoke this consent at any time by telling the referring agency, except to the extent that action has been taken in reliance on it. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

*This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent. However, by signing this release, I understand that Skagit County can have no control over the confidentiality of the contents of my records after they have been released and I hereby release Skagit County from any liability whatsoever for having provided such information, including any materials that may inadvertently be disclosed in complying with this request to the above-referenced agency.*

This Authorization will expire six months from the date of signature or when I sign the Consent for Release of Information upon admission to Mental Health Court, whichever occurs sooner.

Date: \_\_\_\_\_  
Signature of Client \_\_\_\_\_