

**Yakima County Superior Court**  
**MENTAL HEALTH COURT (MHC)**  
128 North 2<sup>nd</sup> Street, Room 308  
Yakima, WA 98901  
Phone: (509) 574-2670 Fax: (509) 574-2701

**AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION**

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PREVIOUS NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

I REQUEST AND AUTHORIZE the following agencies:

<input checked="" type="checkbox"/> CWCMS	<input checked="" type="checkbox"/> Department of Corrections
<input checked="" type="checkbox"/> Yakima County Jail Mental Health Team	<input checked="" type="checkbox"/> Yakima County Assessment & Referral Services
<input checked="" type="checkbox"/> Yakima County Jail Medical Services	<input type="checkbox"/> Barth Clinic
<input checked="" type="checkbox"/> Yakima County Jail	<input type="checkbox"/> State Casa de Esperanza
<input checked="" type="checkbox"/> Yakima Valley Memorial Hospital	<input type="checkbox"/> Center for Addiction Recovery Education (CARE)
<input checked="" type="checkbox"/> Greater Columbia Behavioral Health (RSN)	<input type="checkbox"/> Merit Resources
<input checked="" type="checkbox"/> Eastern State Hospital	<input type="checkbox"/> Triumph Treatment Services
<input checked="" type="checkbox"/> Catholic Family and Child Services	<input type="checkbox"/> Yakima Neighborhood Health Services
<input checked="" type="checkbox"/> Yakima Farmer Worker's Clinic	<input type="checkbox"/> Veteran's Administration, Yakima
<input checked="" type="checkbox"/> District Court/City of Yakima Probation	<input type="checkbox"/> Other: _____

TO RELEASE, COMMUNICATE, AND EXCHANGE THE FOLLOWING INFORMATION AND RECORDS REGARDING ME TO AND WITH THE **YAKIMA COUNTY SUPERIOR COURT, MENTAL HEALTH COURT (MHC) and any of its participating MHC Team agencies and agents:**

Medical Diagnosis and Treatment     including STD and HIV/AIDS  
 Alcohol and Drug Abuse Treatment  
 All Mental Health Information: evaluations, tests, treatment, medications, treatment plans, and progress reports  
 Criminal History     Custody records     Probation records  
 Educational and school records

The above information will be used for the purpose of (a) providing referral information for determining my eligibility and suitability for participation in the Yakima County Mental Health Court (MHC), (b) 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.

This information may, by implied or express authority from me, be disclosed to third parties as necessary in good faith for my referral to and/or participation in Mental Health Therapeutic Court. This authorization applies to all requested information you currently possess and all future information you acquire within the time limits of this Authorization.

I understand I do not have to sign this authorization. I understand that my medical, mental health, and alcohol/substance treatment records are otherwise protected and confidential under Federal and/or Washington State law including 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.

**This authorization may be revoked at any time by providing notice in writing to the agencies listed above, except to the extent that action has already been taken in good faith reliance on it. However, I understand that this will result in my termination of eligibility and participation in MHC.** Unless revoked by me, this Authorization is valid for 90 days for purposes of referral to the Yakima County MHC and if accepted as a participant is valid until 90 days following the completion or termination of my participation in MHC. I waive my right to a shorter duration of this Authorization.

This authorization may be photocopied for duplication as necessary for the use in gathering additional information.

DATED: \_\_\_\_\_

PATIENT Signature \_\_\_\_\_