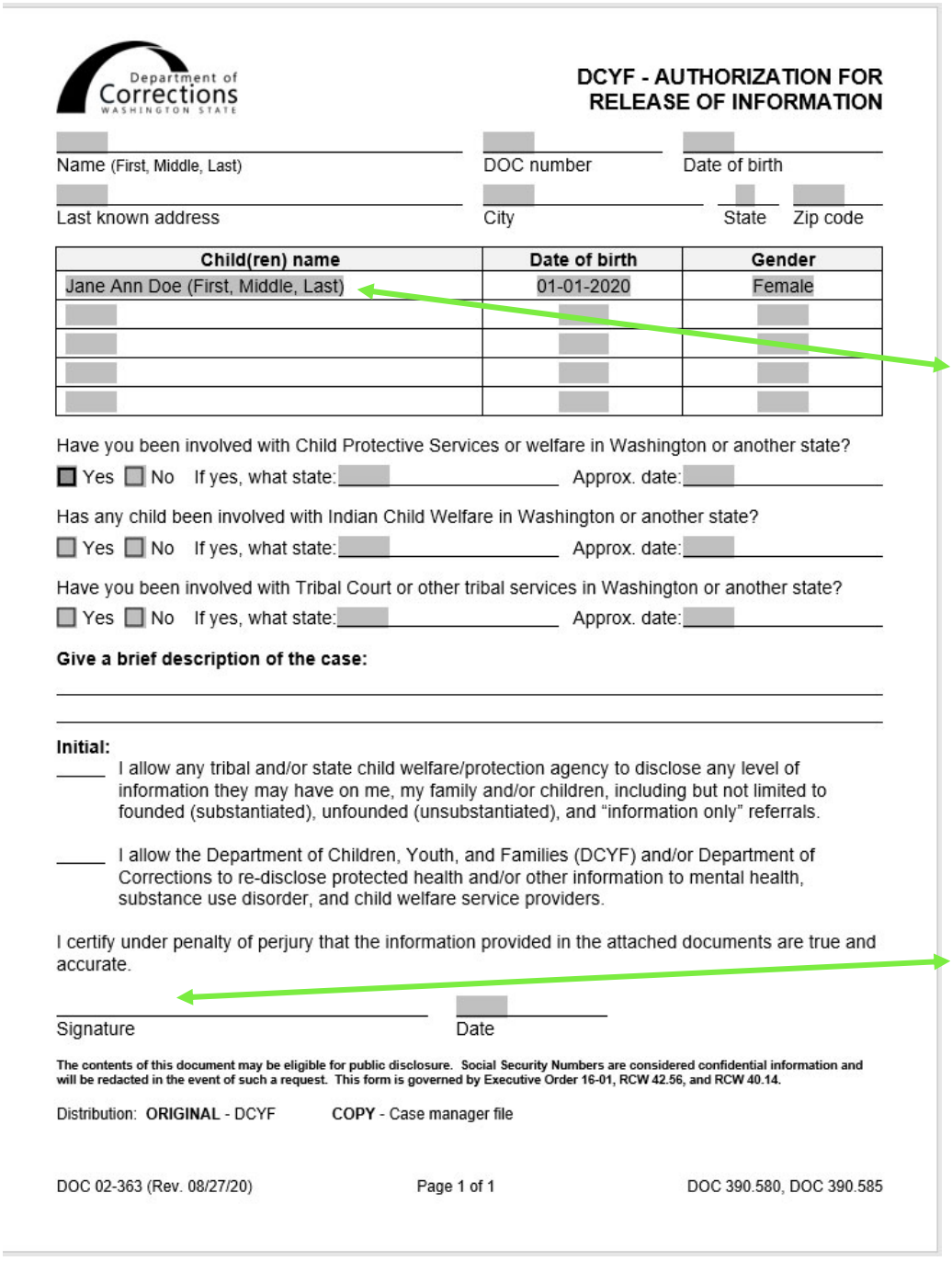
THESE FORMS ARE FOR BOTH CPA and FOSA PROGRAMS

FORM DOC 02-363 DCYF – AUTHORIZATION FOR RELEASE OF INFORMATION



Department of Corrections
WASHINGTON STATE

DCYF - AUTHORIZATION FOR RELEASE OF INFORMATION

Name (First, Middle, Last) | DOC number | Date of birth

Last known address | City | State | Zip code

Child(ren) name	Date of birth	Gender
Jane Ann Doe (First, Middle, Last)	01-01-2020	Female

Have you been involved with Child Protective Services or welfare in Washington or another state?
☐ Yes ☐ No If yes, what state: _____ Approx. date: _____

Has any child been involved with Indian Child Welfare in Washington or another state?
☐ Yes ☐ No If yes, what state: _____ Approx. date: _____

Have you been involved with Tribal Court or other tribal services in Washington or another state?
☐ Yes ☐ No If yes, what state: _____ Approx. date: _____

Give a brief description of the case:

Initial:

_____ I allow any tribal and/or state child welfare/protection agency to disclose any level of information they may have on me, my family and/or children, including but not limited to founded (substantiated), unfounded (unsubstantiated), and "information only" referrals.

_____ I allow the Department of Children, Youth, and Families (DCYF) and/or Department of Corrections to re-disclose protected health and/or other information to mental health, substance use disorder, and child welfare service providers.

I certify under penalty of perjury that the information provided in the attached documents are true and accurate.

Signature | Date

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - DCYF **COPY** - Case manager file

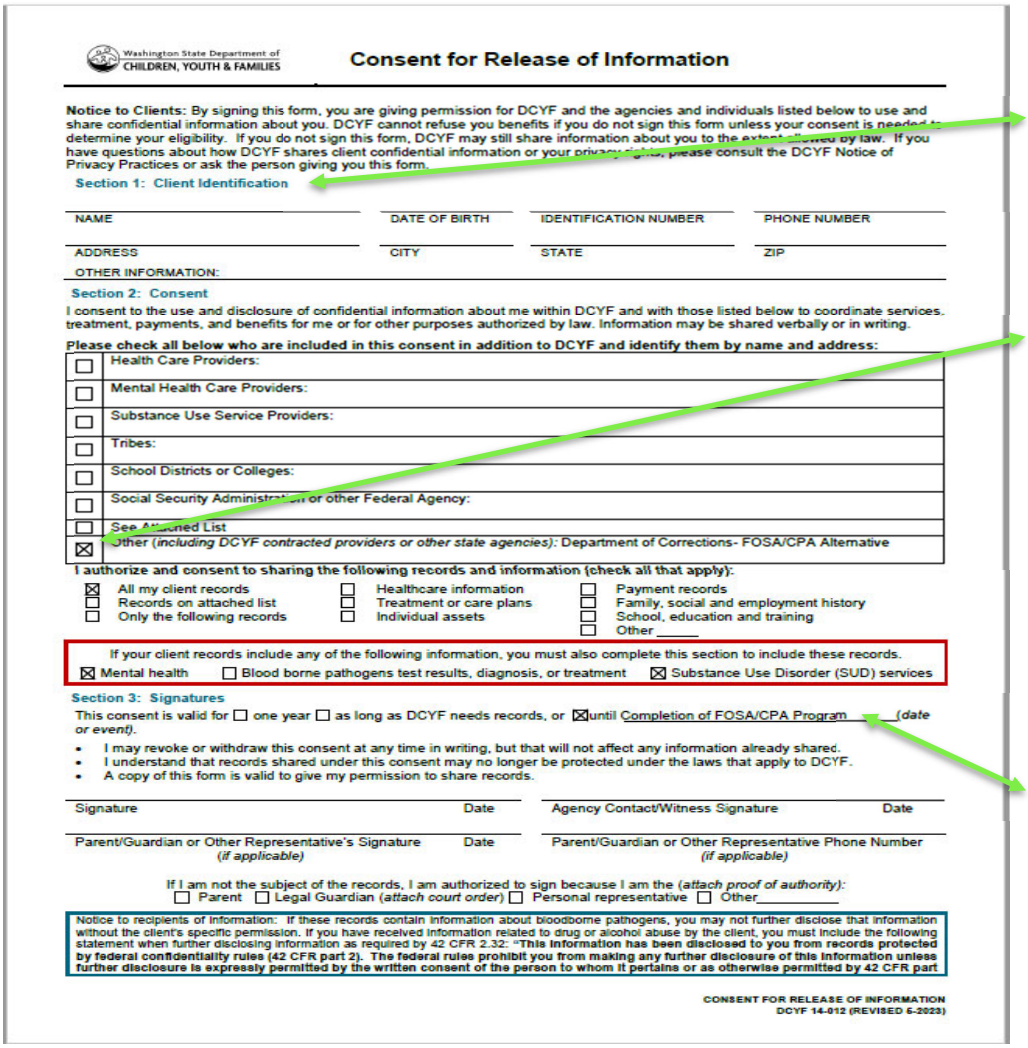
DOC 02-363 (Rev. 08/27/20) Page 1 of 1 DOC 390.580, DOC 390.585

This form should be filled out completely!!

Fill out the children's names completely- first, middle, and last.

Make sure you sign and date it!

FORM DCYF 14-012 Consent for Release of Information



Washington State Department of CHILDREN, YOUTH & FAMILIES

Consent for Release of Information

Notice to Clients: By signing this form, you are giving permission for DCYF and the agencies and individuals listed below to use and share confidential information about you. DCYF cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DCYF may still share information about you to the extent allowed by law. If you have questions about how DCYF shares client confidential information or your privacy rights, please consult the DCYF Notice of Privacy Practices or ask the person giving you this form.

Section 1: Client Identification

NAME | DATE OF BIRTH | IDENTIFICATION NUMBER | PHONE NUMBER

ADDRESS | CITY | STATE | ZIP

OTHER INFORMATION:

Section 2: Consent

I consent to the use and disclosure of confidential information about me within DCYF and with those listed below to coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. Information may be shared verbally or in writing.

Please check all below who are included in this consent in addition to DCYF and identify them by name and address:

- ☐ Health Care Providers:
- ☐ Mental Health Care Providers:
- ☐ Substance Use Service Providers:
- ☐ Tribes:
- ☐ School Districts or Colleges:
- ☐ Social Security Administration or other Federal Agency:
- ☐ See Attached List
- ☒ Other (*including DCYF contracted providers or other state agencies*): Department of Corrections- FOSA/CPA Alternative

I authorize and consent to sharing the following records and information (check all that apply):

- ☒ All my client records
- ☐ Records on attached list
- ☐ Only the following records
- ☐ Healthcare information
- ☐ Treatment or care plans
- ☐ Individual assets
- ☐ Payment records
- ☐ Family, social and employment history
- ☐ School, education and training
- ☐ Other _____

If your client records include any of the following information, you must also complete this section to include these records.

☒ Mental health ☐ Blood borne pathogens test results, diagnosis, or treatment ☒ Substance Use Disorder (SUD) services

Section 3: Signatures

This consent is valid for ☐ one year ☐ as long as DCYF needs records, or ☒until Completion of FOSA/CPA Program (*date or event*).

- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that records shared under this consent may no longer be protected under the laws that apply to DCYF.
- A copy of this form is valid to give my permission to share records.

Signature | Date | Agency Contact/Witness Signature | Date

Parent/Guardian or Other Representative's Signature (*if applicable*) | Date | Parent/Guardian or Other Representative Phone Number (*if applicable*)

If I am not the subject of the records, I am authorized to sign because I am the (*attach proof of authority*):
☐ Parent ☐ Legal Guardian (*attach court order*) ☐ Personal representative ☐ Other_____

Notice to recipients of information: If these records contain information about bloodborne pathogens, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32: "**This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part**

CONSENT FOR RELEASE OF INFORMATION
DCYF 14-012 (REVISED 6-2023)

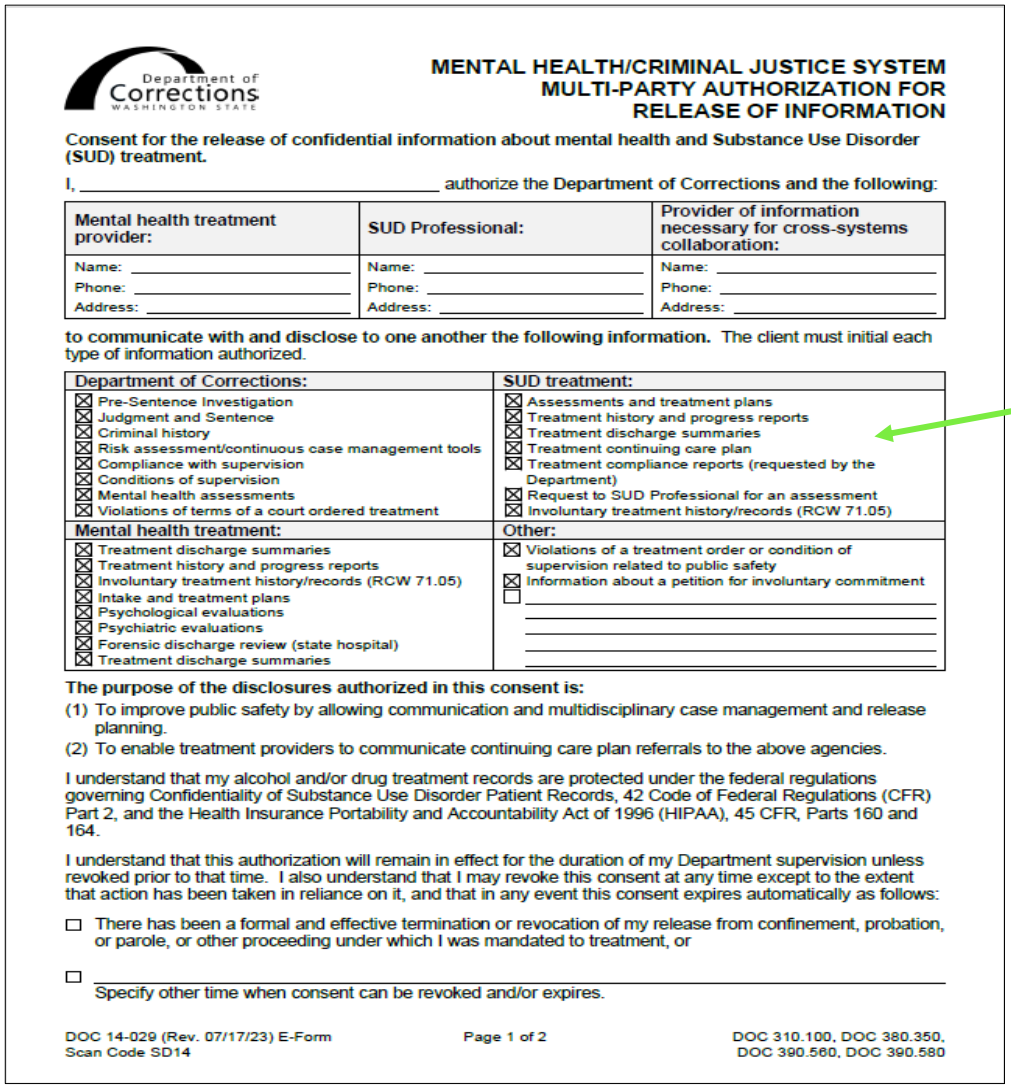
Section 1- "Client Identification" Fill out as it states. IDENTIFICATION NUMBER is your Social Security number or DOC number.

Section 2- "Consent" The only box that needs to be marked is the last one titled "Other." You will need to put in Department of Corrections- FOSA/CPA Alternative.

Under the part that starts "I authorize and consent…", you will mark as follows- "All my client records."

Section 3- "Signatures" You will need to mark the box in front of "until" and in the space put- "Completion of FOSA/CPA program."

FORM DOC 14-029 MENTAL HEALTH/CRIMINAL JUSTICE SYSTEM MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION



Department of Corrections
WASHINGTON STATE

MENTAL HEALTH/CRIMINAL JUSTICE SYSTEM MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

Consent for the release of confidential information about mental health and Substance Use Disorder (SUD) treatment.

I, _____ authorize the **Department of Corrections and the following:**

Mental health treatment provider:	SUD Professional:	Provider of information necessary for cross-systems collaboration:
Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Address: _____	Address: _____	Address: _____

to communicate with and disclose to one another the following information. The client must initial each type of information authorized.

Department of Corrections:	SUD treatment:
☒ Pre-Sentence Investigation ☒ Judgment and Sentence ☒ Criminal history ☒ Risk assessment/continuous case management tools ☒ Compliance with supervision ☒ Conditions of supervision ☒ Mental health assessments ☒ Violations of terms of a court ordered treatment	☒ Assessments and treatment plans ☒ Treatment history and progress reports ☒ Treatment discharge summaries ☒ Treatment continuing care plan ☒ Treatment compliance reports (requested by the Department) ☒ Request to SUD Professional for an assessment ☒ Involuntary treatment history/records (RCW 71.05)
Mental health treatment:	**Other:**
☒ Treatment discharge summaries ☒ Treatment history and progress reports ☒ Involuntary treatment history/records (RCW 71.05) ☒ Intake and treatment plans ☒ Psychological evaluations ☒ Psychiatric evaluations ☒ Forensic discharge review (state hospital) ☒ Treatment discharge summaries	☒ Violations of a treatment order or condition of supervision related to public safety ☒ Information about a petition for involuntary commitment ☐ _____

The purpose of the disclosures authorized in this consent is:

(1) To improve public safety by allowing communication and multidisciplinary case management and release planning.

(2) To enable treatment providers to communicate continuing care plan referrals to the above agencies.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164.

I understand that this authorization will remain in effect for the duration of my Department supervision unless revoked prior to that time. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

☐ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment, or

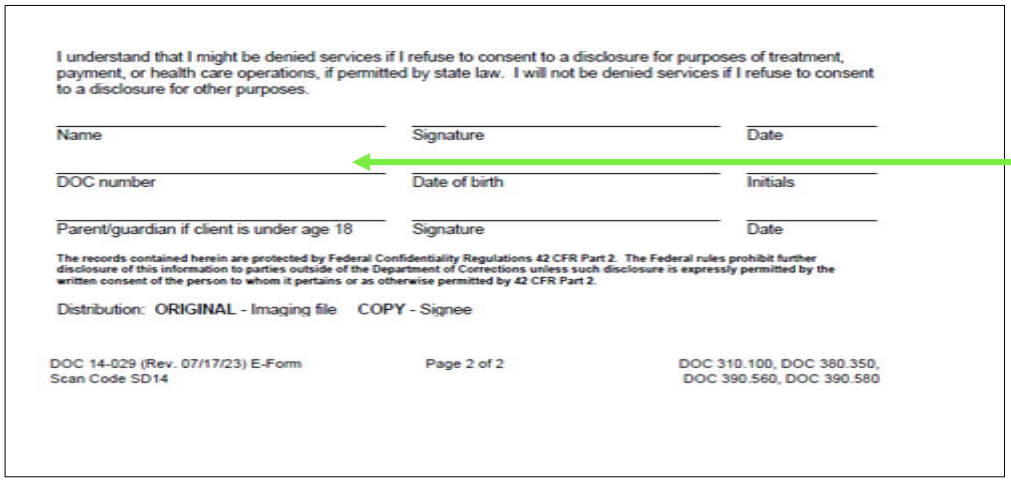
☐ _____
Specify other time when consent can be revoked and/or expires.

DOC 14-029 (Rev. 07/17/23) E-Form
Scan Code SD14

Page 1 of 2

DOC 310.100, DOC 380.350, DOC 390.560, DOC 390.580

Mark boxes like this!



I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Name	Signature	Date
DOC number	Date of birth	Initials
Parent/guardian if client is under age 18	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** - Imaging file **COPY** - Signee

DOC 14-029 (Rev. 07/17/23) E-Form
Scan Code SD14

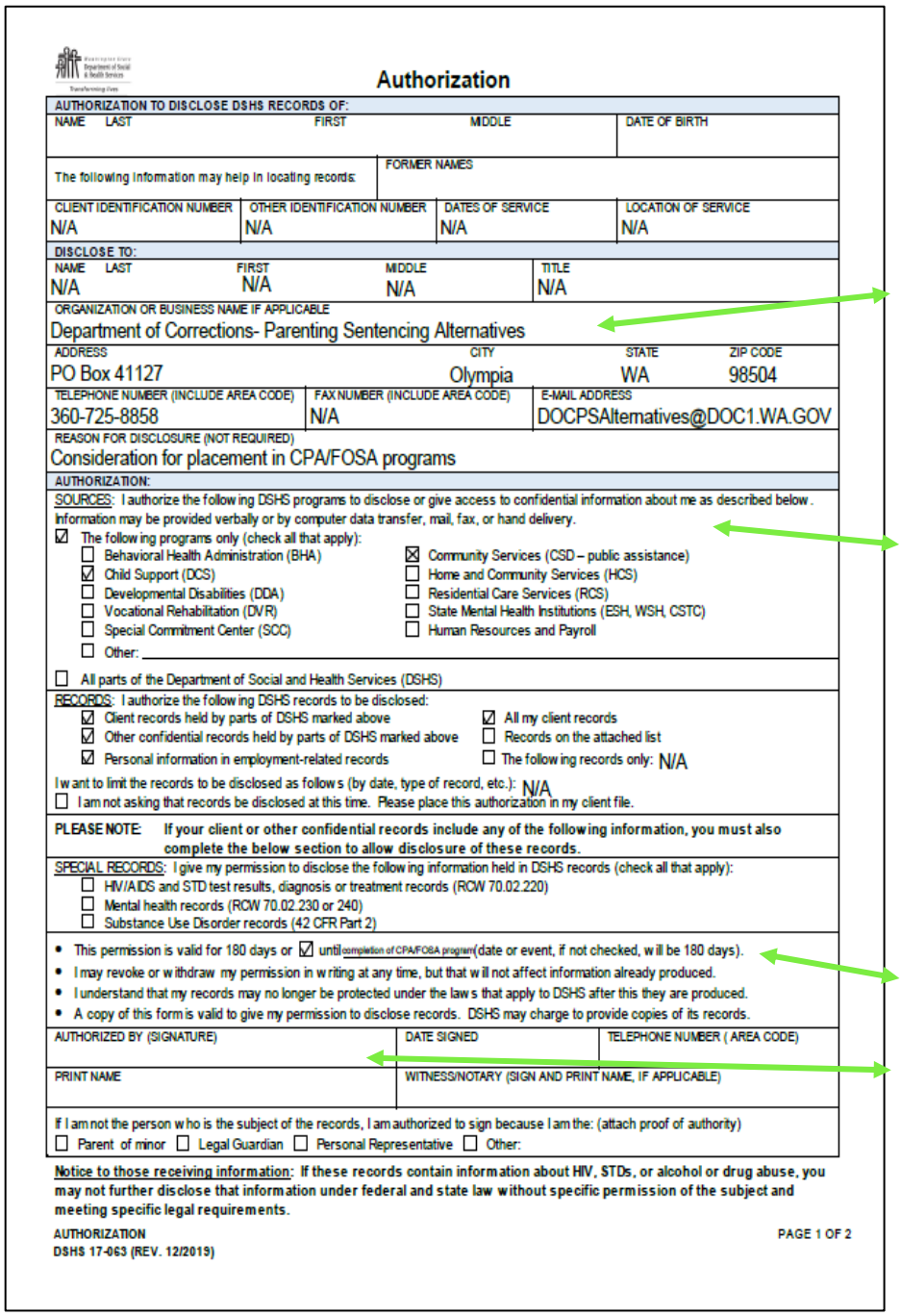
Page 2 of 2

DOC 310.100, DOC 380.350, DOC 390.560, DOC 390.580

Fill out page 2 completely.

If you do not have a DOC number or you do not remember it, you can leave it blank.

FORM DSHS 17-063 Authorization



Authorization

AUTHORIZATION TO DISCLOSE DSHS RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

The following information may help in locating records: FORMER NAMES

CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE
N/A	N/A	N/A	N/A

DISCLOSE TO:

NAME LAST	FIRST	MIDDLE	TITLE
N/A	N/A	N/A	N/A

ORGANIZATION OR BUSINESS NAME IF APPLICABLE
Department of Corrections- Parenting Sentencing Alternatives

ADDRESS	CITY	STATE	ZIP CODE
PO Box 41127	Olympia	WA	98504

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS
360-725-8858	N/A	DOCPSAlternatives@DOC1.WA.GOV

REASON FOR DISCLOSURE (NOT REQUIRED)
Consideration for placement in CPA/FOSA programs

AUTHORIZATION:

SOURCES: I authorize the following DSHS programs to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.

☑ The following programs only (check all that apply):

- ☐ Behavioral Health Administration (BHA)
- ☑ Child Support (DCS)
- ☐ Developmental Disabilities (DDA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Special Commitment Center (SCC)
- ☐ Other:
- ☒ Community Services (CSD – public assistance)
- ☐ Home and Community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC)
- ☐ Human Resources and Payroll

☐ All parts of the Department of Social and Health Services (DSHS)

RECORDS: I authorize the following DSHS records to be disclosed:

- ☑ Client records held by parts of DSHS marked above
- ☑ Other confidential records held by parts of DSHS marked above
- ☑ Personal information in employment-related records
- ☑ All my client records
- ☐ Records on the attached list
- ☐ The following records only: N/A

I want to limit the records to be disclosed as follows (by date, type of record, etc.): N/A

☐ I am not asking that records be disclosed at this time. Please place this authorization in my client file.

PLEASE NOTE: If your client or other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

SPECIAL RECORDS: I give my permission to disclose the following information held in DSHS records (check all that apply):

- ☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220)
- ☐ Mental health records (RCW 70.02.230 or 240)
- ☐ Substance Use Disorder records (42 CFR Part 2)

- This permission is valid for 180 days or ☑ until completion of CPA/FOSA program (date or event, if not checked, will be 180 days).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
- I understand that my records may no longer be protected under the laws that apply to DSHS after this they are produced.
- A copy of this form is valid to give my permission to disclose records. DSHS may charge to provide copies of its records.

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (AREA CODE)

PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other:

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

AUTHORIZATION
DSHS 17-063 (REV. 12/2019)

PAGE 1 OF 2

Under “Authorization to Disclose Records of:”

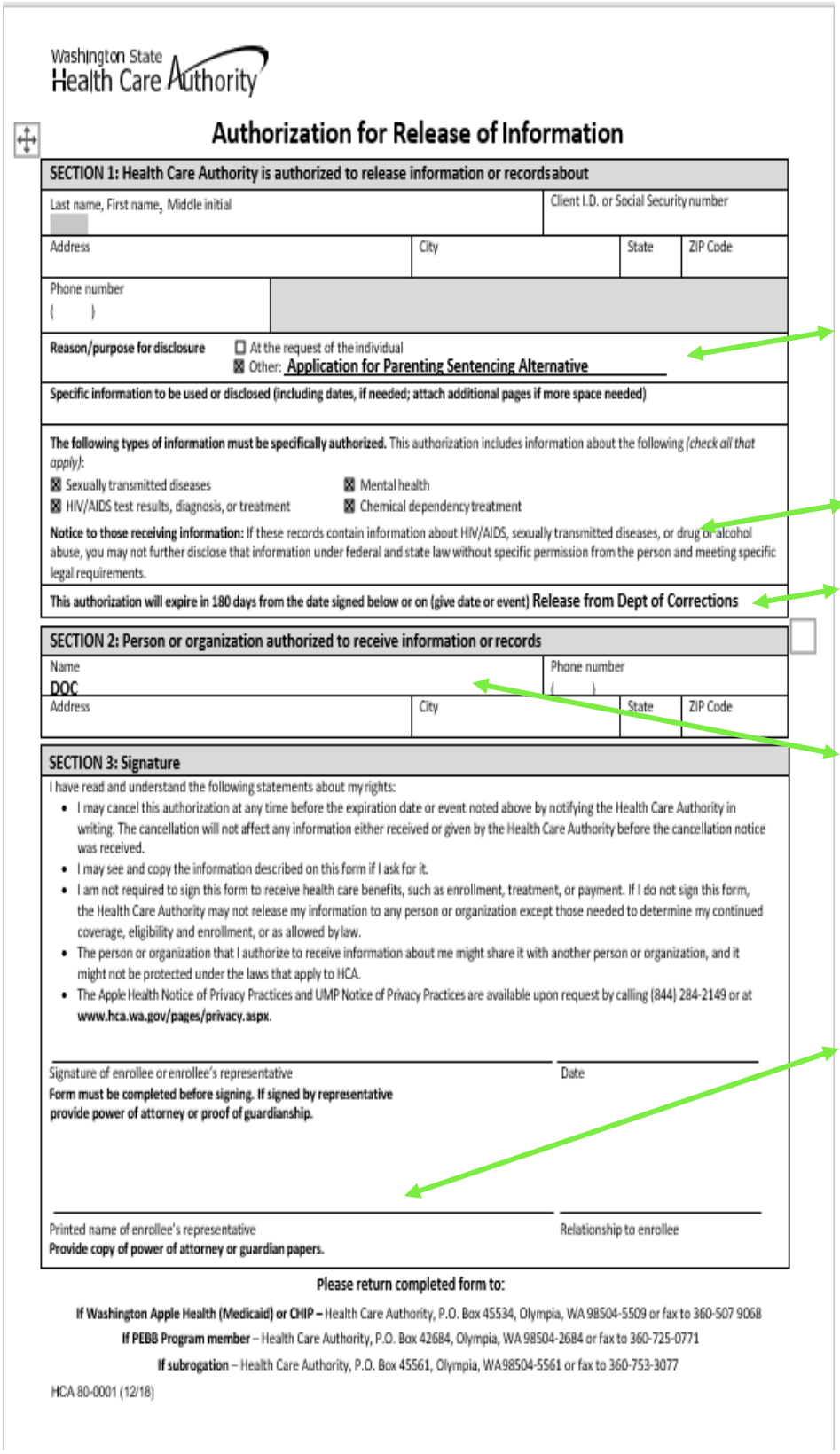
- Please fill out your name and date of birth.

Under “Disclose To:”
- Please fill out as shown here.

Under “Authorization:”
- Mark all the boxes as shown here.

Under “This permission is valid…”
- Mark the box in front of “until” and write- “completion of CPA/FOSA program.”
- Sign and date, add telephone number, and print name.

FORM HCA 80-0001 Authorization for Release of Information



Washington State Health Care Authority

Authorization for Release of Information

SECTION 1: Health Care Authority is authorized to release information or records about

Last name, First name, Middle initial		Client I.D. or Social Security number	
Address	City	State	ZIP Code
Phone number ( )			

Reason/purpose for disclosure ☐ At the request of the individual ☒ Other: Application for Parenting Sentencing Alternative

Specific information to be used or disclosed (including dates, if needed; attach additional pages if more space needed)

The following types of information must be specifically authorized. This authorization includes information about the following *(check all that apply)*:

☒ Sexually transmitted diseases ☒ Mental health
☒ HIV/AIDS test results, diagnosis, or treatment ☒ Chemical dependency treatment

Notice to those receiving information: If these records contain information about HIV/AIDS, sexually transmitted diseases, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission from the person and meeting specific legal requirements.

This authorization will expire in 180 days from the date signed below or on (give date or event) Release from Dept of Corrections

SECTION 2: Person or organization authorized to receive information or records

Name DOC		Phone number ( )	
Address	City	State	ZIP Code

SECTION 3: Signature

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time before the expiration date or event noted above by notifying the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility and enrollment, or as allowed by law.
- The person or organization that I authorize to receive information about me might share it with another person or organization, and it might not be protected under the laws that apply to HCA.
- The Apple Health Notice of Privacy Practices and UMP Notice of Privacy Practices are available upon request by calling (844) 284-2149 or at **www.hca.wa.gov/pages/privacy.aspx**.

Signature of enrollee or enrollee's representative | Date

Form must be completed before signing. If signed by representative provide power of attorney or proof of guardianship.

Printed name of enrollee's representative | Relationship to enrollee

Provide copy of power of attorney or guardian papers.

Please return completed form to:

If Washington Apple Health (Medicaid) or CHIP – Health Care Authority, P.O. Box 45534, Olympia, WA 98504-5509 or fax to 360-507 9068

If PEBB Program member – Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684 or fax to 360-725-0771

If subrogation – Health Care Authority, P.O. Box 45561, Olympia, WA 98504-5561 or fax to 360-753-3077

HCA 80-0001 (12/18)

Section 1 - Fill out as stated.

Under "**Reason/purpose for disclosure**"
- Mark the "other" box and write "Application for Parenting Sentencing Alternative."

Under "**The following types….**"
- Mark all four boxes

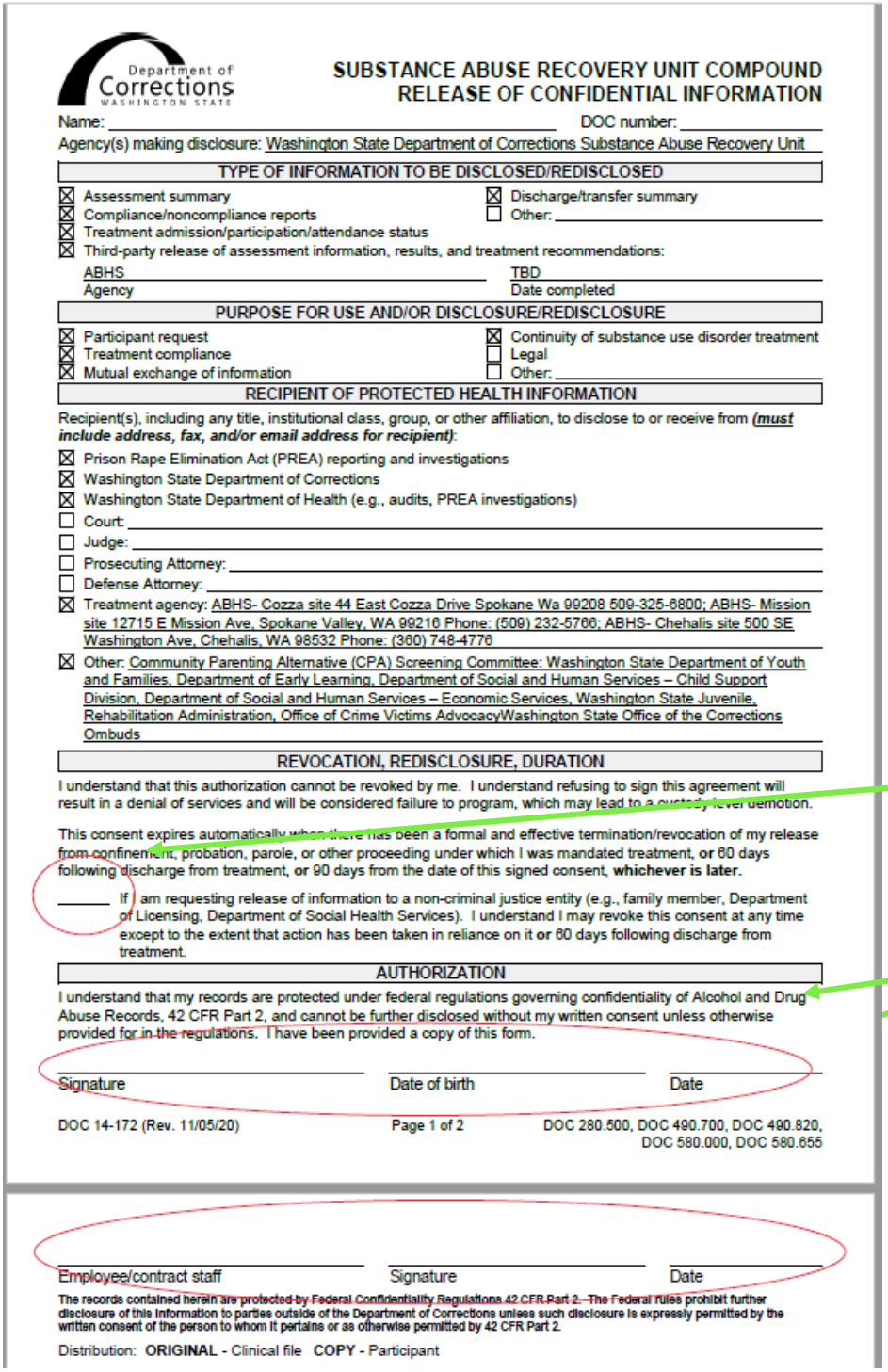
Under "**This authorization will expire**…"
- Write "Release from Dept of Corrections."

Section 2 – You can just write "DOC" under NAME and nothing else needed in this section.

Section 3 – Sign and date

THIS LAST ONE IS FOR CPA ONLY

FORM DOC 14-172 SUBSTANCE ABUSE RECOVERY UNIT COMPOUND RELEASE OF CONFIDENTAIL INFORMATION



Department of Corrections
WASHINGTON STATE

SUBSTANCE ABUSE RECOVERY UNIT COMPOUND RELEASE OF CONFIDENTIAL INFORMATION

Name: _____ DOC number: _____

Agency(s) making disclosure: Washington State Department of Corrections Substance Abuse Recovery Unit

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:
  - ABHS (Agency) — TBD (Date completed)
- ☒ Discharge/transfer summary
- ☐ Other: _____

PURPOSE FOR USE AND/OR DISCLOSURE/REDISCLOSURE

- ☒ 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: ABHS- Cozza site 44 East Cozza Drive Spokane Wa 99208 509-325-6800; ABHS- Mission site 12715 E Mission Ave, Spokane Valley, WA 99216 Phone: (509) 232-5766; ABHS- Chehalis site 500 SE Washington Ave, Chehalis, WA 98532 Phone: (360) 748-4776
- ☒ Other: Community Parenting Alternative (CPA) Screening Committee: Washington State Department of Youth and Families, Department of Early Learning, Department of Social and Human Services – Child Support Division, Department of Social and Human Services – Economic Services, Washington State Juvenile, Rehabilitation Administration, Office of Crime Victims AdvocacyWashington State Office of the Corrections Ombuds

REVOCATION, REDISCLOSURE, 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 _____

DOC 14-172 (Rev. 11/05/20) Page 1 of 2 DOC 280.500, DOC 490.700, DOC 490.820, DOC 580.000, DOC 580.655

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

Fill out your name and DOC number at the top.

Under "Agency making disclosure:"
- Add "Washington State Department of Corrections"

Please mark all boxes as shown

Under "**REVOCATION, REDISCLOSURE, DURATION**"
- Initial that one line.

Under **AUTHORIZATION**,
- Sign, birthdate, and date.
- The bottom signature should be signed and dated by your counselor or the staff member that is helping you out with the form.

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE REACH OUT TO THE UNIT FOR HELP.