 **SEX OFFENSE TREATMENT**

**AND ASSESSMENT PROGRAMS**

**RELEASE OF CONFIDENTIAL INFORMATION**

Name:       DOC number:

Agency(ies) making disclosure:

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| **TYPE OF INFORMATION TO DISCLOSE** |

[ ]  Treatment admission/participation/attendance/ [ ]  Treatment documents/psychological reports

 completion status [ ]  Compliance/non-compliance reports

[ ]  Assessment results/treatment recommendations [ ]  Discharge/transition summary

[ ]  Individual treatment plan [ ]  Other:

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| **PURPOSE FOR USE AND/OR DISCLOSURE** |

[ ]  Patient request [ ]  Continuity of sexual offense treatment

[ ]  Treatment compliance/progress [ ]  Legal

[ ]  Mutual exchange of information (verbal/written) [ ]  Other:

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| **RECIPIENT OF PROTECTED HEALTH INFORMATION** |

Information may be disclosed to and used by the following individual(s) or organization:

Name/organization:

Address:

Information may be delivered by written report, assessments, court reports, court staffing, secure electronic transmittal, and/or fax

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| **REVOCATION, REDISCLOSURE, AND DURATION** |

I understand this authorization cannot be revoked by me and I will be denied services if I refuse to consent to disclosure for the purpose of treatment services. This consent will expire automatically 90 days from the date of this signed consent.

 If I am subject to Indeterminate Sentence Review Board jurisdiction, this consent will terminate upon the expiration of my maximum sentence or the granting of final discharge.

 If I am subject to the Sentencing Reform Act, this consent will terminate upon the expiration of community supervision.

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| **AUTHORIZATION** |

I understand that authorizing the disclosure of my sex offense treatment records is voluntary and I may refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed per RCW 70.02. I understand that any disclosure of information carries the potential for an unauthorized re-disclosure and may not be protected by state confidentiality rules. If I have questions about disclosure of my health information, I may contact the Sex Offense Treatment and Assessment Program.

Signature Date Date of birth

Witness 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.**

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