Department of Corrections
WASHINGTON STATE

# SEX OFFENDER TREATMENT AND ASSESSMENT PROGRAMS RELEASE OF CONFIDENTIAL INFORMATION

Name: _____ DOC number: _____

Agency(ies) making disclosure: _____

## TYPE OF INFORMATION TO DISCLOSE

- ☐ Treatment admission/participation/attendance/ completion status
- ☐ Assessment results/treatment recommendations
- ☐ Individual treatment plan
- ☐ Treatment documents/psychological reports
- ☐ Compliance/non-compliance reports
- ☐ Discharge/transition summary
- ☐ Other: _____

## PURPOSE FOR USE AND/OR DISCLOSURE

- ☐ Patient request
- ☐ Treatment compliance/progress
- ☐ Mutual exchange of information (verbal/written)
- ☐ Continuity of sexual offense treatment
- ☐ Legal
- ☐ Other: _____

## 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

## 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.

## 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 Offender 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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