**AUTHORIZATION FOR RELEASE**

**OF CUSTODIAL INFORMATION**

I,       hereby authorize

to release a copy of the information indicated below to:

     

Name Representing

Mailing address City, state, and zip code

The information is released for the following reasons:

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| **INFORMATION THAT CAN BE RELEASED** |

Educational history  Reports to court/Board

Random urinalysis (UA) results  Assessment or reassessment of risk forms

Treatment progress  Risk Classification/Supervision Plan interview data

Pre-sentence report  Court or Board Orders

Criminal history  Other (specify):

**Release of medical, dental, and mental health information, use DOC 13-035 Authorization for Disclosure of Health Information.**

**Release of drug and alcohol treatment information, use DOC 14-172 Substance Abuse Recovery Unit Compound Release of Confidential Information.**

Release expiration will be at the time of release or at the discretion of the individual being supervised by the Department. Consent is subject to revocation at any time.

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| **AUTHORIZATION** |

           

Signature DOC number Date of birth Date signed

     

Witness name Signature Date signed

Processed by (name, title, date) Scanned by (name, title, date)

**Prohibition on re-disclosure:** These records have been disclosed to you from records of which confidentiality is protected. Any further re-disclosure is strictly prohibited. Any authorization specifying “Any and All” information will not be honored.

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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