



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:

INFORMATION THAT CAN BE RELEASED

- Educational history
- Random urinalysis (UA) results
- Treatment progress
- Pre-sentence report
- Criminal history
- Reports to court/Board
- Assessment or reassessment of risk forms
- Risk Classification/Supervision Plan interview data
- Court or Board Orders
- 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.

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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