

# THESE FORMS ARE FOR BOTH CPA and FOSA PROGRAMS DO NOT FILL OUT- THESE ARE SAMPLES

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

Department of Corrections		JTHORIZATION FOR E OF INFORMATION	This form should be filled out
Name (First, Middle, Last)	DOC number	Date of birth	completely!!
Last known address	City	State Zip code	
Child(ren) name	Date of birth	Gender	
Jane Ann Doe (First, Middle, Last)	01-01-2020	Female	
			Fill out the children's names
			completely- first, middle, and last.
Has any child been involved with Indian Child We Yes No If yes, what state:  Have you been involved with Tribal Court or other Yes No If yes, what state:  Give a brief description of the case:	Approx. date	on or another state?	
Initial:  I allow any tribal and/or state child welfare information they may have on me, my fam founded (substantiated), unfounded (unsu  I allow the Department of Children, Youth, Corrections to re-disclose protected health substance use disorder, and child welfare I certify under penalty of perjury that the informatiaccurate.	nily and/or children, including the stantiated), and "information and Families (DCYF) and/or and/or other information to service providers.	g but not limited to on only" referrals. or Department of o mental health,	→ Make sure you sign and date it!
4			
Signature	Date		
The contents of this document may be eligible for public disclosure. will be redacted in the event of such a request. This form is governe	Social Security Numbers are conside d by Executive Order 16-01, RCW 42.5	red confidential information and 6, and RCW 40.14.	
Distribution: ORIGINAL - DCYF COPY - Case man		•	
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#### FORM DCYF 14-012 Consent for Release of Information

share deten have Priva	e to Clients: By signing this form, you e confidential information about you. D group your eligibility. If you do not sign questions about how DCYF shares cli cy Practices or ask the person giving	CYF cannot refuse you this form, DCYF may lent confidential inform	u benefits if yo still share info	u do not sign this form rmation about you to th	unless your conse	ent is needed by law. If you
Sec	tion 1: Client Identification					
NAM	/E	DATE OF BIRTH	IDENT	FICATION NUMBER	PHONE NUM	BER
ADD	RESS	CITY	STATE		ZIP	
ОТН	ER INFORMATION:					
treatn	sent to the use and disclosure of confi nent, payments, and benefits for me o se check all below who are included I Health Care Providers:	r for other purposes a	uthorized by la	w. Information may be	shared verbally or	in writing.
Ш						
	Mental Health Care Providers:					
	Substance Use Service Providers:					
	Tribes:					
П	School Districts or Colleges:					
$\overline{\Box}$	Social Security Administration or oth	er Federal Agency:				
H	See Attached List			TE TIME	A contract of	151
×	Other (including DCYF contracted po	roviders or other state	agencies): De	partment of Corrections	s- FOSA/CPA Alte	mative
I au	Records on attached list	following records and Healthcare inform Treatment or care Individual assets	nation	(check all that apply) Payment records Family, social and School, education Other	d employment hist	ory
	If your client records include any of t	he following informatio	n. vou must al		n to include these	records.
M		hogens test results, di			e Use Disorder (S	
Sect	tion 3: Signatures					
	consent is valid for one year as	s long as DCYF needs	records, or	until Completion of FC	SA/CPA Progran	(date
	I may revoke or withdraw this consen I understand that records shared und A copy of this form is valid to give my	er this consent may no	longer be pro			
Sign	nature	Date	e Ager	ncy Contact/Witness Sig	gnature	Date
Pare	ent/Guardian or Other Representative (if applicable)	's Signature Date	e Pare	nt/Guardian or Other R (if ap	lepresentative Phoplicable)	one Number
	If I am not the subject of the Parent Legal Guar	e records, I am authoriz rdian (attach court orde	zed to sign bed er) Person:	ause I am the (attach pal representative   0	proof of authority):	
with	ce to recipients of information: If these re out the client's specific permission, if you h ement when further disclosing information;	have received information as required by 42 CFR 2.	related to drug .32: "This inform	or alcohol abuse by the c	lient, you must included to you from rec	de the following ords protected

<u>Section 1</u>- "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."

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#### FORM HCA 80-0001 Authorization for Release of Information

6/13/2025

Autnoriz	ation for Release	of Infor	mation	1	
SECTION 1: Health Care Authority is aut	horized to release informatio				
Last name, First name, Middle initial		0	lient I.D. or S	iocial Securi	tynumber
Address	City	I		State	ZIP Code
Phone number ( )					
	quest of the individual pplication for Parenting Sent	encing Altern	ative		4
Specific information to be used or disclosed (incl				eded)	
The following types of information must be speci appily):  Sexually transmitted diseases  HIV/AIDS test results, diagnosis, or treatment	ifically authorized. This authorization  Mental health Chemical dependency t		ation about	the followin	g (check all that
Notice to those receiving information: If these re abuse, you may not further disclose that informat legal requirements.	cords contain information about HIN ion under federal and state law with	//AIDS, sexually out specific perm	nission from t	the person a	and meeting specific
This authorization will expire in 180 days from th	e date signed below or on (give dat	e or event) Rele	ease from l	Dept of Co	orrections 👉
SECTION 2: Person or organization auth	orized to receive information				
Name DOC		P	hone numbe	r	
Address	City			State	ZIP Code
SECTION 3: Signature					
I have read and understand the following stateme I may cancel this authorization at any time b writing. The cancellation will not affect any i was received. I may see and copy the information describe I am not required to sign this form to receiv the Health Care Authority may not release n coverage, eligibility and enrollment, or as all The person or organization that I authorize t might not be protected under the laws that.	refore the expiration date or event n information either received or given l ed on this form if I ask for it. e health care benefits, such as enroll my information to any person or orga lowed by law. so receive information about me mig- apply to HCA.	by the Health Car Iment, treatment Inization except tht share it with a	t, or payment those needed nother perso	t. If I do not d to determi	sign this form, ine my continued
<ul> <li>The Apple Health Notice of Privacy Practices www.hca.wa.gov/pages/privacy.aspx.</li> </ul>			Date		
www.hca.wa.gov/pages/privacy.aspx.  Signature of enrollee or enrollee's representative					
www.hca.wa.gov/pages/privacy.aspx.					
www.hca.wa.gov/pages/privacy.aspx.  Signature of enrollee or enrollee's representative  Form must be completed before signing. If signe  provide power of attorney or proof of guardiansi  Printed name of enrollee's representative	hip.		Relationship	to enrollee	:
www.hca.wa.gov/pages/privacy.aspx.  Signature of enrollee or enrollee's representative  Form must be completed before signing. If signer	hip.	m to:	Relationship	to enrollee	

**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."

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

Section 3 – Sign and date

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### Form DCYF 17-063 Authorization

AUTHORIZATION TO DIS	CLOSE DEDARTM		orization	Control of the Contro	DECORDS OF	-	Under "Authorization to Disclose Records of:"
NAME, LAST	CLUSE DEFARTIM	FIRST	, TOUTH AND	MIDDLE	DATE OF BIRTH		Records of.
The following information r	nay bala in location	FORMER NAME	8		LOYAN SANS	4	
records	nay neip in locating						- Please fill out your name and date of
CLIENT IDENTIFICATION NUMB		IFICATION NUMBER	DATES OF S	ERVICE	LOCATION OF SERVICE		•
N/A	N/A	CONTRACTOR OF THE PARTY OF THE	N/A		N/A	3	birth.
DISCLOSE TO: NAME, LAST	FIRST		MIDE	N. F.	TITLE		
PSA PSA	FIRST		MID	ALE .	· · ·		Under "Disclose To:"
ORGANIZATION OR BUSINESS			(50)		· ·	→	0 2.00.000 . 0.
Department of Correction	ons		CITY	STA	TE ZIP CODE		Please fill out as shown here.
PO Box 41127		Olyn		WA			
TELEPHONE NUMBER (INCLUD		FAX NUMBER (INCLUDE	The second second	E-MAIL AD	DRESS	-	
360-725-8858		N/A		DOCPS	Alternative@doc1.wa.gov		
REASON FOR DISCLOSURE (NO Consideration for the pl		EOCA programa					
AUTHORIZATION:	acement in CFA/i	OSA programs				-	
	the following DCYF	programs to disc	lose or give a	access to confidentia	al information about me as	4	
described below. Inform							
0		1400 0		2500 190		-43	Under "Authorization:"
The following programs		t apply):					Mania all the alcourage and accomplished
	abilitation programs			All my client recor	rds		<ul> <li>Mark all the boxes as shown here.</li> </ul>
	ntial records held by		ed above	Records on the at			
☐ Personal info	rmation in employme	nt-related records		☐ The following reco			
☐ Personal info		nt-related records		☐ The following reco		2	
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Personal information All parts of the RECORDS: I authorize Client records hother confidention Personal information I want to limit the record PLEASE NOTE: must also complete SPECIAL RECORDS: I HIV/AIDS and Sometime Mental health record Chemical Dependent of the Person who I understand that my A copy of this form is AUTHORIZED BY (BIGNATURE)  FRINT NAME    I am not the person who Parent of minor   I Notice to those receiving Notice to those receiving Policy I authorized that the property of the person who Parent of minor I Notice to those receiving Notice to the Notice to those receiving Notice Notice to those receiving Notice to the N	mation in employmente Department of Country the following DCY eld by parts of DC' all records held by attion in employments to be disclosed a lift your client or the below section. The test results, discords (RCW 70.00 and for the discords (RCW 70.00 and	children, Youth, an Frecords to be dis YF marked above parts of DCYF ma htt-related records as follows (by date of the confidence on to allow discont to disclose the fagnosis or treatme 2.230 or 240) dis (42 CFR Part 2 limit) until marked parts of the confidence on to disclose the fagnosis or treatme 2.230 or 240) dis (42 CFR Part 2 limit) are presented ermission to disclose the fagnosis or treatme 2.230 or 240) dis (42 CFR Part 2 limit) are presented ermission to disclose the fagnosis or treatment are presented ermission to disclose the fagnosis of the fagnosis or treatment are presented ermission to disclose the fagnosis of the	d Families (I sclosed:	The following recond CYF)  I my client records on the efollowing records on the efollowing records or the efollowing records or the efollowing records.  The series of the efollowing records or the efollowing records.  The series of the efollowing records or the efollowing records.  The series of the efollowing records or the efo	attached list only:  attached list only:  the following information, you of the following information already produced.  The following information of the following information already produced.  The following information of the following information info		<ul> <li>- Mark the box in front of "until" and write- "completion of CPA/FOSA program."</li> <li>- Sign and date, add telephone number</li> </ul>

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Date Created:6/13/2025Date Modified:6/13/2025Created By:Elliott, Lori M. (DOC)Modified By:

AUTHORIZATION DCYF 17-063 (rev.01/2019) INT/EXT



### **FOSA PARTICIPANTS ONLY FOR THIS ONE**

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

Consent for the release of conf (SUD) treatment.	fidential information	n about mental	neutri dila Sabstance ose Disordei	
	autho	rize the Depart	ment of Corrections and the following:	
Mental health treatment provider:	SUD Profession	onal:	Provider of information necessary for cross-systems collaboration:	
Name:	Name:		Name:	
Phone:	Phone: Address:			
		the following i	Address:  nformation. The client must initial each	
ype of information authorized.		TO MAKE		
Department of Corrections:		SUD treatmen		Mark boxes like this!
⊠ Pre-Sentence Investigation     Use Judgment and Sentence     Criminal history     Risk assessment/continuous ca     Compliance with supervision     Conditions of supervision     Mental health assessments     Violations of terms of a court ord			is and treatment plans istory and progress reports ischarge summaries ontinuing care plan ompliance reports (requested by the ) SUD Professional for an assessment treatment history/records (RCW 71.05)	Walk boxes like this:
Mental health treatment:		Other:	a treatment order or condition of	
Treatment discharge summaries Treatment history and progress Involuntary treatment history/rec Intake and treatment plans Psychological evaluations Psychiatric evaluations From the control of the contr	reports cords (RCW 71.05)	supervision	a treatment order or condition or related to public safety about a petition for involuntary commitment	
Forensic discharge review (state	e hospital)			
Treatment discharge summaries	5	<u> </u>		
planning.  (2) To enable treatment provider I understand that my alcohol and governing Confidentiality of Subs Part 2, and the Health Insurance 164. I understand that this authorizatic revoked prior to that time. I also	allowing communicati s to communicate co Wor drug treatment re stance Use Disorder! Portability and Acco	entinuing care placecords are protected attent Records untability Act of the duration and revoke this control of the control of the duration and revoke this control of the duration and revoke the duration and revok	ciplinary case management and release an referrals to the above agencies.  sted under the federal regulations (AZ Code of Federal Regulations (CFR) 1996 (HIPAA), 45 CFR, Parts 160 and  of my Department supervision unless management at any time except to the extent consent expires automatically as follows:	
planning.  2) To enable treatment provider understand that my alcohol and poverning Confidentiality of Subsert 2, and the Health Insurance 164.  understand that this authorization evoked prior to that time. I also hat action has been taken in reliable the provider of th	allowing communications to communicate conflored to the stance Use Disorder Portability and Accoon will remain in effect understand that I manance on it, and that in effective termination gunder which I was in the stance of th	on and multidisc entinuing care place Patient Records untability Act of ct for the duration by revoke this con an any event this nor revocation of mandated to treat	an referrals to the above agencies.  cted under the federal regulations, 42 Code of Federal Regulations (CFR) 1996 (HIPAA), 45 CFR, Parts 160 and  n of my Department supervision unless insent at any time except to the extent consent expires automatically as follows:  f my release from confinement, probation,	
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Date Created:6/13/2025Date Modified:6/13/2025Created By:Elliott, Lori M. (DOC)Modified By:



### THIS LAST TWO ARE FOR CPA ONLY

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

		COVERY UNIT COMPOUND		
Corrections WASHINGTON STATE	RELEASE OF COM	NFIDENTIAL INFORMATION		
Name:		DOC number:	→ Fill out your name and DOC	
Agency(s) making disclosure: Washingt	on State Department of Corrections-	Substance Abuse Recovery Unit	number at the top.	
TYPE OF INFO	RMATION TO BE DISCLOSED/RE	DISCLOSED		
Assessment summary Compliance/noncompliance reports treatment admit, participation and dischar	Other: V	ge/transfer summary e <u>rbal communication related to</u>	<ul><li>Under "Agency making disclosited "Washington State</li></ul>	ure:"
Treatment admission/participation/atte		ons.	<ul> <li>Department of Corrections-</li> </ul>	
Third-party release of assessment info		ommendations:	Substance Abuse Recovery Un	it"
Agency	Date cor	•	<u> </u>	
	USE AND/OR DISCLOSURE/REI			
<ul> <li>☑ Participant request</li> <li>☑ Treatment compliance</li> <li>☑ Mutual exchange of information</li> </ul>	Continui	ty of substance use disorder treatment	nt	
<ul> <li>☐ Treatment compliance</li> <li>☐ Mutual exchange of information</li> </ul>	☑ Legal ☐ Other:		Please mark all boxes as show	'n
	OF PROTECTED HEALTH INFO	RMATION	<u> </u>	
Recipient(s), including any title, institution			_	
include address, fax, and/or email add	ress for recipient):	disclose to of receive from (must		
Prison Rape Elimination Act (PREA)				
Washington State Department of Corn		-\		
Washington State Department of Hea	ith (e.g., audits, PREA investigations	3)		
Judge:			<del>_</del>	
Prosecuting/Defense Attorney:			_	
Treatment agency:			_	
○ Other: Community Parenting Alternat	tive (CPA) Screening Committee: W	ashington State Department of Youth		
and Families, Department of Social at Human Services – Economic Services	nd Human Services - Child Support	Division, Department of Social and	_	
REVOC	ATION, REDISCLOSURE, DURA	TION		
I understand that this authorization canno result in a denial of services and will be co	t be revoked by me. I understand re	efusing to sign this agreement will	Under "REVOCATION, REDISCLOSURE,	
This consent expires automatically when from confinement, probation, parole, or ot	there has been a formal and effectiv	e termination/revocation of my release	DURATION" -Initial that one line.	
following discharge from treatment. or 90	days from the date of this signed co	onsent, whichever is later.	- Illitial triat one line.	
of Licensing, Department of Soc	ormation to a non-criminal justice ent sial Health Services). I understand I nas been taken in reliance on it or 60	ity (e.g., family member, Department may revoke this consent at any time 0 days following discharge from		
	AUTHORIZATION			
I understand that my records are protecte Abuse Records, 42 CFR Part 2, and cann provided for in the regulations. I have been	not be further disclosed without my w	g confidentiality of Alcohol and Drug ritten consent unless otherwise	Under AUTHORIZATION, -Sign, birth date, and date.	
			The bottom signature should	be
Signature	Date of birth	Date	signed and dated by your counselor or the staff member	that
Employee/contract staff	Signature	Date	is helping you out with the forn	
DOC 14-172 (Rev. 09/03/24)		C 280.500, DOC 490.700, DOC 390.585, C 490.850, DOC 580.000, DOC 580.655		

 Date Created:
 6/13/2025
 Date Modified:
 6/13/2025

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### FORM DSHS 17-063 Authorization

The reservation from the reservation of the reserva	uthorization			Under "Authorization to Disclose
AUTHORIZATION TO DISCLOSE DSHS RECORDS OF:				Records of "
NAME LAST FIRST	MDDLE	DATE OF BIRTH	1	Necolus of.
F	ORMER NAMES		-	B
The following information may help in locating records:	orther review			- Please fill out your name and date of
CLIENT IDENTIFICATION NUMBER OTHER IDENTIFICATION NU		LOCATION OF SERVICE	1	birth.
VA N/A	N/A	N/A		
DISCLOSE TO: NAME LAST FIRST M	IDDLE TITLE		-	Under "Disclose To:"
A1/A	VA N/A			- Please fill out as shown here.
ORGANIZATION OR BUSINESS NAME IF APPLICABLE				- 1 lease iii out as shown here.
Department of Corrections- Parenting Senter	ncing Alternatives	STATE ZIP CODE	4	
O Box 41127	Olympia	WA 98504		
	NCLUDE AREA CODE) E-MAIL ADD		1	
60-725-8858 N/A	DOCPS	Alternatives@DOC1.WA.GOV		
REASON FOR DISCLOSURE (NOT REQUIRED)		<u> </u>		
Consideration for placement in CPA/FOSA pr AUTHORIZATION:	rograms		-	
SOURCES: I authorize the following DSHS programs to disclo	se or give access to confidential info	ormation about me as described below.	1	
information may be provided verbally or by computer data trai				Under "Authorization:"
☑ The following programs only (check all that apply): ☐ Behavioral Health Administration (BHA)	Community Services (CSD – pu	(blic assistance)		- Mark all the boxes as shown here.
☐ Child Support (DCS)	☐ Home and Community Services			
Developmental Disabilities (DDA)	Residential Care Services (RC			
□ Vocational Rehabilitation (DVR)     □ Special Commitment Center (SCC)	☐ State Mental Health Institutions ☐ Human Resources and Payroll			
Other:				
☐ All parts of the Department of Social and Health Services	(DSHS)			
RECORDS: I authorize the following DSHS records to be disc			1	
☑ Client records held by parts of DSHS marked above ☑ Other confidential records held by parts of DSHS ma	All my client reco arked above Records on the a			
Personal information in employment-related records	The following rec			
want to limit the records to be disclosed as follows (by date		5.55 5). [WA		
I am not asking that records be disclosed at this time. Re	ase place this authorization in my clie	ent file.		
PLEASE NOTE: If your client or other confidential re-		g information, you must also	1	
complete the below section to allow SPECIAL RECORDS: I give my permission to disclose the follo		de (aback all that annh-):	4	
☐ HIV/AIDS and STD test results, diagnosis or treatmen		us (crieck all triat apply).		
Mental health records (RCW 70.02.230 or 240)	,			
Substance Use Disorder records (42 CFR Part 2)			-	Under "This permission is valid…"
This permission is valid for 180 days or ☑ until completion of				·
<ul> <li>I may revoke or withdraw my permission in writing at any</li> <li>I understand that my records may no longer be protected.</li> </ul>				- Mark the box in front of "until" and
<ul> <li>A copy of this form is valid to give my permission to disclo</li> </ul>	***			write- "completion of CPA/FOSA
AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER ( AREA CODE)	1	program."
				- Sign and date, add telephone number
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)	1	and print name.
☐ Parent of minor ☐ Legal Guardian ☐ Personal Repr		(unabli proof of authority)		
Notice to those receiving information: If these record		STDs, or alcohol or drug abuse. vou	_	
may not further disclose that information under feder				
meeting specific legal requirements.				
AUTHORIZATION DSHS 17-063 (REV. 12/2019)		PAGE 1 0	)F 2	

# IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE REACH OUT TO THE UNIT FOR HELP. DOCPSAlternative@doc1.wa.gov

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