WHATCOM COUNTY
DISTRICT COURT PROBATION
Whatcom County Courthouse
311 Grand Avenue, Suite 406
Bellingham, WA 98225

PHONE: (360) 778-5450
FAX: 360-778-5451

BRUCE VAN GLUBT
Administrator

PEGGY MILLER
Probation Manager

MUTUAL CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____(DOB:__________________________) authorize

Whatcom County District Court Probation and ____

(Phone: ________________________Fax:_____________________Address:________________________) to

exchange information from my records for the ☐ purpose of facilitating evaluation and treatment, or ☐ other:_________

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I request the following information to be released: (*Client initials required on checked items*)

- ☐ Alcohol/Drug use history, diagnostic impressions, symptomology Init:_________
- ☐ Biographical, family, psychological and social history Init:_________
- ☐ Evaluation results and recommendations Init:_________
- ☐ Previous treatment history and success/compliance Init:_________
- ☐ Abstinence status, progress reports, attendance records Init:_________
- ☐ Discharge/ Treatment summary, aftercare plans, prognosis Init:_________
- ☐ Results of urinalysis, breathalyzer, and/or lab tests Init:_________
- ☐ Compliance with Alcohol and Drug Information School Init:_________
- ☐ Other:____ Init:_________
- ☐ Other:____ Init:_________

I understand that my alcohol and / or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g., Tuberculosis, HIV/AIDS-AID- related illness), mental health services, drug and/or alcohol services. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized re-disclosure is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization.

In any event this authorization expires automatically as follows: 1 (one) year from date of signature. Init:______________

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Initiated on this ___________ day of __________________, 20___.

______________________________ ______________________________
Signature of participant *Staff/Witness signature*

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Signature of parent, guardian or authorized representative