SNOHOMISH COUNTY MENTAL HEALTH COURT

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Mental Health Court Fax Number: 425-388-6397

This information has been disclosed to you from records whose confidentiality is protected by the Federal Confidentiality Regulations (42 CFR, part 2) that prohibits disclosure of records without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization of release of medical or other information is not sufficient for this purpose.

NAME:____ **DOB:**_________________________

I hereby authorize the mutual exchange of information (verbal and written) between the following Mental Health Court Team Members to freely discuss my Mental Health Court case:

Mental Health Court	Prosecutor's Office
Public Defender's Office	Probation Office
Mental Health Agency:	
Substance Use Treatment Agency:	
Carnegie Resource Center Reception	
Snohomish County Jail	Other:

I understand Team Members will freely discuss the facts of my case and my compliance or noncompliance in any treatment program. ________________(INITIAL)

I understand any information obtained by this release will be used solely for my participation in the program and will remain confidential between Mental Health Court Team Members. ________________(INITIAL)

I understand that this release is required for my participation in Mental Health Court. ________________(INITIAL)

I further understand that my drug and/or alcohol treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Pts. 160 & 164, and cannot be disclosed without any written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g. Tuberculosis, HIV/AIDS/AIDS related illness), mental health services, drug and/or alcohol services. I also understand that I may revoke this consent in writing at any time except to the extent that this action has been taken in reliance on it, including provisions of heath care services requiring subsequent disclosure to affect payment. Unauthorized re-disclosure by recipient 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:

This release authorization automatically expires 24 months from date of authorization, or termination and/or graduation from the Snohomish County Mental Health Court program, whichever occurs sooner.

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Client Signature Date