Public Health
Seattle & King County

Court Clinician and Community Support Services

The Public Health Seattle-King County, Jail Health Services Court Clinician services provides eligibility determination and treatment planning for various therapeutic courts to include; Regional Mental Health Court (RMHC), Regional Veteran's Court (RVC), City of Seattle Mental Health Court (SMC MHC) City of Seattle Veterans Treatment Court (VTC).

COURT CLINICIAN SERVICES: Eligibility for these therapeutic courts is based on a number of factors. Your Court Clinician will assess and review with you your program eligibility. For participants who are found eligible for a therapeutic court a treatment plan for opting into the court will be developed by you and your Court Clinician for final approval by the court.

COMMUNITY SUPPORT SERVICES: For participants who are in RMHC and are in need of support connecting to and engaging with community based treatment, housing, benefits and other resources the Community Support Specialist can assist. The Community Support Specialist can take participants to appointments, assist with obtaining benefits and meeting other court obligations.

Offering Court Clinician and Community Support services in a therapeutic court creates a partnership between you and your defense attorney, the prosecutor's office, probation, and your behavioral health services in the community.

CONFIDENTIALITY: Your Court Clinician and the Community Support Specialist coordinates your behavioral health care with your community providers and other members of the court team. Written permission is required to disclose your health care information outside of your health care

Jail Health Services

500 5th Avenue
Seattle, WA 98104
Ph: 206.296.1091
Fax: 206.296.1771

620 West James St
Kent, WA 98032
Ph: 206.477.2100
Fax: 206.205-2439

PATIENT NAME:

BA #: **HRN:**

DOB: **SEX:**

providers or as permitted or required by law. The Court Clinicians and Community Support Specialist are required by law to report the following conditions to the proper authorities: Child abuse or dependent adult abuse (physical or sexual); or if you express intent or ideation to harm yourself or another person. Homelessness by itself is not considered child abuse or neglect.

MY RIGHTS: I understand that I do not have to sign this consent to get health care benefits (treatment, payment, enrollment, or eligibility) or to receive services from Jail Health Services or any other providers. However, if I refuse to sign this consent to services I will not be eligible to participate further in RMHC/RVC or SMC MHC/VTC screening process.

EXPIRATION: Unless it is revoked, this consent will expire upon graduation from the court or when I withdraw from, or am discharged from, the Regional Mental Health Court/Veterans Court or City of Seattle Veteran's Treatment Court. "Discharge" means ineligibility for further services through Regional Mental Health Court or Veterans Court, unless formally re-referred to the program. It is not the same as being placed in inactive status due to lack of recent contact; the consent continues in effect while a participant is "inactive" unless the participant revokes consent.

If you choose to receive RMHC/RVC or SMC MHC/VTC Court Clinician services from Public Health Seattle-King County Jail Health Services please sign below.

_____ **Yes:** I would like to receive Court Clinician Services from Public Health Seattle & King County Jail Health Services.

_____ **No:** I would not like to receive Court Clinician Services from Public Health Seattle & King County Jail Health Services. By declining Court Clinician services I understand that my referral into Regional Mental Health Court or Veteran's court will closed as this time.

Signature:_____ **Date:**_____

PATIENT NAME:

BA #: **HRN:**

DOB: **SEX:**

AUTHORIZATION FOR CARE COORDINATION

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned authorizes Public Health or its staff to exchange information (written or verbal) to the persons or organizations identified below for the purpose of ongoing care coordination. A Care Coordination Authorization form is needed for each client.

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released, unless I check any of the boxes below.

When checked, this consent excludes release of the following types of information:

☐ Drug or alcohol abuse diagnosis or treatment
☐ Confirmed STD test results and/or treatment
☐ Psychiatric care/mental illness
☐ HIV (AIDS) testing/treatment

Release of Information is authorized for:

Client Last Name: _____ Client First Name: _____ DOB: _____

Alias: _____

X _____ _____ _____ _____

Signature of Client or Guardian | Relationship | Witness or Interpreter | Date

Records will be released to:

Agency Name	Telephone	Contact Person	Date
KC Dept. of Public Defense			
KC Prosecuting Attorney's Office			
KC RVC Probation			
KC Victims Advocate			
DSHS			
WDVA			
PHS			
RVC/RMHC (Open Court)			

This authorization may be renewed three times. Unless revoked or as otherwise provided herein, this authorization expires _____ **(insert either applicable date or event)**. If this authorization requests that health information be used by or disclosed to the client's employer or a Financial Institution, this authorization will expire 90 days from the date signed.

Signature _____ Date _____

Client rights on the second page

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Seattle & King County

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620 West James St
Kent, WA 98032
Ph: 206.205.2400
FAX: 206.205-2439

New/Revised – ROI: Authorization for Care Coordination – Form #2 (Rev. 09 – 2015)

PATIENT NAME:
BA #: **HRN:**
CCN: **DOB:**
BOOKING DATE: **SEX:**
LOCATION:

* 495- 1959387- 5045- 00000000- *

AUTHORIZATION FOR CARE COORDINATION

Your rights under federal and state law:

You may revoke this authorization at any time. It will be in writing. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable.
Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form.
When Public Health asks you to fill out this authorization, you are entitled to a copy.
You may ask to have this authorization expire sooner.
When Public Health discloses your health information, your protected health information can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

AUTHORIZATION TO DISCLOSE AND REDISCLOSE PROTECTED HEALTH INFORMATION
FOR THE JAIL HEALTH SERVICES COURT SERVICES CARE TEAM

Name: _____ **Date of Birth:** _____

I authorize the following entities to disclose and re-disclose my health care information to and among themselves: King County Public Health- Jail Health Services Court Services Team, King County Regional Mental Health/Veterans Court (RMCH/RVC Team, and Seattle Municipal Mental Health Court/Veteran's Treatment Court (SMC MHC/VTC) Team, which includes staff from the following entities:

☒	RMHC/RVC Probation	☒	King County Superior Court	☒	Seattle City Attorney's Office
☒	SMC SMH/VTC Probation	☒	Department of Corrections	☒	Washington Dept. of Veterans Affairs
☒	King County Prosecutor's Office	☒	King County District Court	☒	DCHS/Behavioral Health and Recovery
☒	King County Department of Public Defense	☒	King County Public Health, Jail Health Services – Court Services Team	☒	Veterans Administration Puget Sound/Lakewood
☒	King County Victim Advocate	☒	Seattle Municipal Court	☒	King County District Court Probation

Purpose of the disclosure: To coordinate treatment activities, including assessment, referral, medical, substance use disorder, mental health, vocational, shelter and/or housing services.

Information to be disclosed and re-disclosed. Please check all appropriate boxes:

☒	Name	☒	Date of Birth	
☒	This authorization form	☐	HIV status and treatment	
☒	Past or present mental health problems or diagnoses	☒	Past or present physical health problems	
☒	Initial and subsequent evaluations of my services needs by the Release Planning Care Team and its members	☒	Past or present substance use disorder problems or diagnoses	
☒	Current and past mental health treatment programs, with date	☒	Current and past chemical dependency treatment programs, with dates	
☒	Current and past emergency department visits, with dates	☐	Other:	

By signing this form, I understand:

- When I am asked to fill out this authorization, I am entitled to a copy.
- I have the right to revoke this authorization at any time. It must be in writing and sent to the ***Originating Agency*** listed below. Any revocation will not take effect if action has already been taken based on the original authorization.
- Without my express revocation, this authorization will expire (insert date or event, invalid if left blank)_____.
- The information disclosed and re-disclosed may contain information on my current/past: Mental health, drug or alcohol use, and/or HIV status, and I authorize the disclosure and re-disclosure for the purposes of this authorization.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2.
- I understand that this authorization is voluntary, it will not affect my ability to obtain health care services from the individual health care providers identified above, but will limit the ability of the workgroup members to discuss my needs and coordinate my care.

Signature:_____ **Date:** _____

AUTHORIZATION TO DISCLOSE AND REDISCLOSE PROTECTED HEALTH INFORMATION
FOR THE JAIL HEALTH SERVICES COURT SERVICES CARE TEAM

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Seattle & King County

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Ph: 206.296.1091
Fax: 206.296.1771

620 West James St
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Ph: 206.477.2100
Fax: 206.205-2439

PATIENT NAME:

BA #: **HRN:**

DOB: **SEX:**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
JAIL HEALTH SERVICES

Public Health is not obligated to honor this request unless all portions are completed.

The undersigned authorizes:

☐ Outside Agency (give complete name & address) or ☒ Jail Health Records

_____ _____

_____ _____

_____ _____

To release the records of: _____ _____

Client Name Alias (Optional)

_____ _____

Client Phone # Date of Birth

Records will be released to:

King County Regional Mental Health Court Team

Person & Institution Affiliation

516 Third Ave., Seattle, WA 98104

Street Address City/State/Zip

_____ _____

Phone Number Fax Number (Optional)

Date(s) of services requested: _____

(If no date given: the last incarceration information will be released)

For the purpose of: ☒ medical/dental ☒ legal ☐ personal ☒ other (describe) Treatment Planning

Please verify what you are requesting:

☒ Release Medical Health Records

☐ Other Public Health Medical Records, specify: _____

☒ Verbal Information Exchange: _____

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

When checked, this authorization <u>Excludes</u> release of the following information:

☐ Drug or alcohol abuse diagnosis or treatment ☐ HIV (AIDS) testing/treatment

☐ Confirmed STD test results and/or treatment ☐ Psychiatric

This authorization expires (insert date or event, <u>invalid if left blank</u>) _____

Is the receiver an employer or financial institution? (If yes, this will expire in 90 days) ☐ Yes ☒ No

_____ _____

Client/Guardian Signature Date

_____

Relationship to Patient

_____ _____

Interpreter Date

<u>Your rights under federal and state law:</u>

You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending a written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES

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Seattle & King County

Jail Health Services
500 Fifth Avenue
Seattle, WA 98104
Phone: 206-296-1091
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Jail Health Services
620 W James S.
Kent, WA 98032
Phone: 206-205-2410
Fax: 206-205-2439

Patient Name: _____

BA#: _____

HR#: _____

D.O.B.: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
JAIL HEALTH SERVICES

Public Health is not obligated to honor this request unless all portions are completed.

The undersigned authorizes:

☒ Outside Agency (give complete name & address) or ☐ Jail Health Records

_____ _____

_____ _____

_____ _____

To release the records of: _____ _____

Client Name Alias (Optional)

_____ _____

Client Phone # Date of Birth

Records will be released to:

Seattle - Public Health Jail Health Services - Court Clinician Team

Person & Institution Affiliation

516 Third Ave, Room E-319, Seattle, WA 98104

Street Address City/State/Zip

+1 (206) 477-6283 +1 (206) 259-2763

Phone Number Fax Number (Optional)

Date(s) of services requested: _____

(If no date given: the last incarceration information will be released)

For the purpose of: ☒ medical/dental ☒ legal ☐ personal ☒ other (describe) Treatment Coordination

Please verify what you are requesting:

☒ Release Medical Health Records

☐ Other Public Health Medical Records, specify: _____

☒ Verbal Information Exchange: Diagnosis, treatment recommendation, progress, attendance, medication, appointments

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

When checked, this authorization <u>Excludes</u> release of the following information:

☐ Drug or alcohol abuse diagnosis or treatment ☐ HIV (AIDS) testing/treatment

☐ Confirmed STD test results and/or treatment ☐ Psychiatric

This authorization expires (insert date or event, <u>invalid if left blank</u>) _____

Is the receiver an employer or financial institution? (If yes, this will expire in 90 days) ☐ Yes ☒ No

_____ _____

Client/Guardian Signature Date

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Relationship to Patient

_____ _____

Interpreter Date

<u>Your rights under federal and state law:</u>

You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending a written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

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Kent, WA 98032
Phone: 206-205-2410
Fax: 206-205-2439

Patient Name: _____

BA#: _____

HR#: _____

D.O.B.: _____

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VAPSHCS
1660 S Columbian Way Seattle, WA 98103

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

King County-Seattle Public Health Jail Health Services Court Clinician
King Courty Courthouse, 516 Thrid Ave, Room E-319, Seattle, WA 98104

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Information pertaining to VA eligibility and/or medical, mental health, and addictions treatment information.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Coordination of health care and social services.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
VAPSHCS 1660 S Columbian Way Seattle, WA 98103	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

King County Regional Veteran's Court Team
King County Courthouse, 516 Third Ave., Room E-319, Seattle, WA 98104

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Information pertaining to VA eligibility and/or medical, mental health, and addictions treatment information.

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Coordination of health care and social services.

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AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY