KING COUNTY DRUG DIVERSION COURT SERVICES

516 Third Avenue, Room E-609
Seattle, WA 98104
(206) 477-0788 – Fax: (206) 296-7885

CONSENT FOR THE REDISCLOSURE OF CONFIDENTIAL INFORMATION

CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____ **DOB:** _____
Last Name First Name Middle Initial (MM / DD / YY)

hereby consent to communication between Drug Diversion Court Services whether by phone, mail, FAX or E-Mail, and the agencies listed below:

X	Seattle Municipal Court	X	DSHS-Dept. of Social and Health Services
X	Superior Court	X	Department of Children, Youth & Families
X	King Co. District Court	X	Probation: _____
X	Seattle Police Department	X	DOC-Department of Corrections
X	Defense Attorney	X	DPD-Department of Public Defense
X	Prosecutor's Office	X	Department of Public Health
X	Harborview Medical Center	X	Dept. of Adult and Juvenile Detention
X	Social Security Administration	X	Dept of Community and Human Services
X	Sound	X	Therapeutic Health Services
X	Veteran's Administration	X	WELD Seattle
X	DJA-Dept of Judicial Admin	X	Kate's House
X	Peer Washington	X	AAHAA
X	All DBHR approved treatment agencies	X	Cordant Lab
X	Housing Placement: _____		
X	Other (specify): _____		
X	Personal Contact (specify): _____		

Concerning the following: alcohol/drug use; urinalysis and breath analysis results; oral swab results; alcohol/drug services governed by 42 CFR Part 2, mental health services governed by RCW 71; medical treatment; criminal justice system involvement; psycho-social history; employment; housing; communicable diseases, including sexually transmitted diseases (e.g., HIV/AIDS-related illnesses) and/or: _____.

For the purposes of: facilitating continuity of care and to provide treatment progress information to the Drug Court Judge, and/or: _____.

I understand that this consent will remain in effect and cannot be revoked until there has been a formal and effective termination or revocation of my conditional release from confinement, probation or parole, suspension, diversion, deferral or other proceeding under which I was mandated into treatment.

DATE: **X** _____ **X** _____
Participant Signature

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW AND PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.
FEDERAL REGULATIONS (42CFR, PART 2) *Updated 12.28.23*