



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 voluntarily agree to participate in the King County Drug Diversion Court program (KCDDC).
I have read (or had read to me) and understand this Release of Confidential Information form.

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

authorize **KING COUNTY DRUG DIVERSION COURT SERVICES** to receive and redisclose
information from: _____

Phone: _____ Fax: _____

The purpose of and need for the disclosure is to inform the criminal justice agency (ies) of my attendance at and progress in drug/alcohol treatment and to receive information relevant to my treatment. The extent of information to be disclosed is my **diagnosis**, information about my **attendance or lack of attendance** at treatment sessions, my **cooperation** with the treatment program, my **treatment plan**, my **progress**, **drug and alcohol testing**, **prognosis** and my **discharge summary**.

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.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. I further understand this Consent expires automatically as described above. I acknowledge the information to be released was fully explained to me and that this Consent is given of my own free will. (Title 42, Code of Federal Regulations, Part 2, Confidentiality of Alcohol & Drug Abuse Patient Records).

DATE: X _____ X _____
Participant Signature