



BENTON COUNTY DISTRICT COURT  
THERAPEUTIC COURT REFERRAL:



- MENTAL HEALTH COURT
- VETERAN'S COURT

Please Fax referral packet to: (509) 222-3758

<p>Defendant Name _____</p> <p>DOB _____ Referral Date _____</p> <p>Current Location (Inmate/Address) _____</p> <p>Phone Number _____</p> <p>Defense Attorney _____</p> <p>Defense Attorney Email _____</p>	<p style="text-align: right;"><u>Check if DV</u></p> <p>Case 1 _____ <input type="checkbox"/></p> <p>Charge _____</p> <p>Case 2 _____ <input type="checkbox"/></p> <p>Charge _____</p> <p>Case 3 _____ <input type="checkbox"/></p> <p>Charge _____</p> <p>Case 4 _____ <input type="checkbox"/></p> <p>Charge _____</p>
<p><b>List the agency and/or provider(s) where services are received. If not receiving services, list the last service provider:</b></p> <p>_____</p>	
<p><b>Reason for referral (Required):</b> _____</p> <p>_____</p> <p>_____</p>	
<p>Referred by: <input type="checkbox"/> Judicial Officer      <input type="checkbox"/> Law Enforcement      <input type="checkbox"/> Defense Attorney</p> <p><input type="checkbox"/> Prosecuting Attorney      <input type="checkbox"/> Treatment Provider      <input type="checkbox"/> Probation</p> <p><input type="checkbox"/> Other      <input type="checkbox"/> Jail</p>	
<p>Referring Party – Please Print Name _____ Referring Party's Firm/Agency _____</p> <p>Referring Party's Telephone Number _____ Referring Party's Email Address _____</p>	
<p><b>***ENTIRE REFERRAL PACKET MUST BE COMPLETED***</b></p> <p>Questions? Please contact the Therapeutic Courts office at (509) 735-8476 ext. 3353</p>	



# BENTON COUNTY DISTRICT COURT THERAPEUTIC COURTS



## AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I request and authorize the following agencies:

- Alliance Consistent Care (E. D. Information Exchange)
- 8am-8pm Family Medicine
- Benton County Corrections
- Benton-Franklin Counties Crisis Response
- Benton-Franklin Dept. of Human Svcs.
- Catholic Family Services
- Chaplaincy Behavioral Health
- Columbia Basin Veterans Center
- Comprehensive Mental Health
- Correct Care Solutions (CCS)
- Department of Corrections (WA State)
- Department of Social and Health Services
- Department of Veteran's Affairs

- Domestic Violence Services
- Eastern State Hospital
- First Step Counseling
- Grace Clinic
- Greater Columbia Behavioral Health
- Ideal Option
- Kadlec Health System
- Lourdes Counseling Center
- Lourdes Health Crisis Svcs.
- Lutheran Community Services
- Lynx Healthcare
- Mental Health Ombudsman
- Merit Resource Services
- Nueva Esperanza Counseling

- Oxford Houses of WA
- PACT
- Somerset Counseling
- Sunderland Family Trmt Svcs.
- The Emmaus Center
- Transitions
- Tri-Cities Behavioral Health
- Trios Health
- American Behavioral Health Sys.
- WA State DOH Prescription Monitoring Program
- Other: \_\_\_\_\_

to release and exchange healthcare information of the patient named above to the Benton County Therapeutic Court Teams:

**Benton County District Court  
Therapeutic Courts Staff and team members  
Benton County Public Defender/ Prosecutor  
Benton County Probation**

**7122 W. Okanogan, Bldg A  
Kennewick, WA 99336  
Phone: (509) 735-8476 ext. 3353  
Fax: (509) 222-3758**

This request and authorization applies to:

- Medical Diagnosis and Treatment
- Alcohol and Drug Abuse Treatment
- All Mental health information: treatment plans, intake evaluations, medications, relevant progress reports.
- Re-disclosure of all records:

The above information will be used for the purpose of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring for compliance with a treatment program, including informing the court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis and completion of treatment. I understand the recipient of the above-requested information may re-disclose it, at which time it may no longer be protected under the privacy laws.

**THIS SECTION MUST BE COMPLETED BY PATIENT:**

I understand that my records may be confidential, depending on the information contained in them, under one or more of the following statutes or regulations: Medical Records (including mental health records), RCW 70.02; Drug or Alcohol Treatment Records, RCW 70.96A.150 and/or Code of Federal Regulations, Title 42, volume 1, Part 2 and/or Health Insurance Portability and Accountability Act of 1996. 45 C.F.R. Parts 160 and 164.

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

- Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.
- Yes  No I authorize the release of any records regarding drug, alcohol, hospitalization, counseling, evaluations, medical, progress reports or mental health treatment to the person(s) listed above.

**I understand I do not have to sign this authorization. I understand that at any time I may revoke this authorization; however, the revocation must be in writing. Send to: 7122 W. Okanogan, Bldg. A, Kennewick, WA 99336.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES UPON THE END OF THERAPEUTIC COURT JURISDICTION (this includes probationary period).  
Note: This authorization may be photocopied for duplication as necessary for the use in gathering additional information.

**BENTON COUNTY DISTRICT COURT  
THERAPEUTIC COURTS**

7122 W. OKANOGAN BUILDING A, KENNEWICK, WA 99336, (509) 735-8476 EXTENSION 3353

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Listed below are the basic requirements of Mental Health Court and Veterans Court. You must review the program handbook for a complete list of requirements.

- You must attend all court dates and case management appointments. They are scheduled as follows:
  - Phase 1 – weekly
  - Phase 2 – every 2 weeks
  - Phase 3 – every 3 weeks
  - Phase 4 – monthly
- You may not consume alcohol
- You may not use marijuana or other street drugs
- You must take all of your medications as prescribed
- You must submit to random pill counts to verify medication compliance
- You must call the UA line or utilize the online check in tool daily prior to 8:45 p.m., and submit to random drug testing (UAs, saliva testing) as requested
- You are required to complete a minimum of 20 hours of community service
- You are required to set goals when you enter the program and you must make continuous progress toward achieving your goals
- You must maintain sober housing
- You must attend two therapy appointments per month
- You must see your medication prescriber regularly
- You must participate in any services to which you are referred – chemical dependency treatment, self-help meetings, anger management, pain management, domestic violence, etc.
- You must provide documentation of your attendance at all appointments/meetings
- Veterans Court participants must maintain regular contact with their mentor and attend the evening forum monthly

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Reviewed with: \_\_\_\_\_, Defense attorney