SUPERIOR COURT FOR THE STATE OF WASHINGTON
FOR BENTON AND FRANKLIN COUNTIES
7122 W. Okanogan Place Building A, Kennewick, WA 99336-2341

RELEASE OF INFORMATION

THIS RELEASE EXPRESSLY AUTHORIZES ACCESS TO HEALTH INFORMATION PROTECTED UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).
THIS RELEASE ALSO AUTHORIZES RELEASE OF OTHER INFORMATION AS INDICATED BELOW:

Client's/Patient's Name:_____ Middle:_____ Last:_____

SSN:_____ Birth Date: _____ Maiden/Other Names:_____

Parent/Guardian's Authorization for child/ren:
(Use separate release for additional children)

Child's Name: _____ Birth Date:_____

Child's Name: _____ Birth Date:_____

I understand that information about this case is confidential and may be protected by federal and state law. I understand that once disclosed, this information may be re-disclosed to others and that the information might not be protected under state and federal privacy regulations once released. I may revoke this authorization at any time by writing to the provider but I understand that the cancellation will not affect any use of information that was already released before the cancellation. I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I have a right to inspect or request a copy of health information disclosed under this authorization. I understand what this authorization means and I am satisfied with any explanations I may have requested and received. I certify that I have been provided a copy of this signed authorization. This disclosure authorization is specifically intended to include any references to diagnoses, testing and/or treatment for communicable diseases, including sexually transmitted diseases (HIV/AIDS/AIDS related illnesses), mental health services governed by RCW 70.24, drug and/or alcohol services governed by 42 CFR Part 2.
I request and authorize ANY PUBLIC OR PRIVATE AGENCY, PUBLIC OR PRIVATE SCHOOL, HEALTH CARE PROVIDERS, LAW ENFORCEMENT AGENCIES INCLUDING CHILD PROTECTIVE SERVICES, DEPARTMENT OF CORRECTIONS, SUBSTANCE ABUSE TREATMENT FACILITIES OR MENTAL HEALTH PROVIDERS to release information of the client and the minor children named above to:

Sandra Alarcon - Family Court Investigator
Benton & Franklin Counties Superior Court
7122 W. Okanogan Place, Bldg. A
Kennewick, WA 99336-2341
Phone: 509-736-3071 x 3328
Fax: 509-736-3057 or Email: Sandra.Alarcon@co.benton.wa.us

This request and authorization applies to and may be delivered by fax, mail, hand delivered or released verbally:

Please Initial Each Box

- ☐ DSHS/DCYF Records
- ☐ Electronic Media
- ☐ JABS/ODYSSEY/ICH (Judicial Access Browser System/State Court System/Individual Case History)
- ☐ Drug/Alcohol Records
- ☐ Police Records
- ☐ School Records
- ☐ Employment Records
- ☐ Trios & Kadlec Medical Groups
- ☐ All my Children's health/mental health records
- ☐ All my physical & mental health records (including protected health information)
- ☐ Other: _____

Lourdes, Sundown M Ranch, Domestic Violence Treatment Services, Benton-Franklin Substance Abuse Assessment Center Somerset, Triumph/Casita del Rio, and/or other specifically named agency:_____

This information has been disclosed to you from records protected by federal confidentiality rules (title 5, U.S.C. Sec 552a and 42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it concerns.

_____

Signature of client/patient or client/patient's authorized representative **Date Signed**

AUTHORIZATION EXPIRES UPON COMPLETION OF COURT ACTION THAT INITIATED THIS RELEASE

Rev. 08.28.2019