STATE OF WASHINGTON
KITTITAS COUNTY UPPER AND LOWER DISTRICT COURTS

BEHAVIORAL HEALTH COURT

SCREENING REQUEST FORM
Fax to Compliance Specialist: 509-962-7575 or Email: bhc@co.kittitas.wa.us

Date: _____ Client in Custody: □ Yes / □ No

Name: _____ DOB: _____

Contact: _____ Phone: _____
(Jail / Address)

Case _____ _____
Case Number Charge

_____ _____
Prosecutor Defense

Case _____ _____
Case Number Charge

_____ _____
Prosecutor Defense

Reason(s) for Request (Check all that apply)
□ Possible evidence of substance use disorder
□ Previous or Current Diagnosis: _____
□ Possible suicide risk/danger to others
□ Possible inability to care for self in or outside of the jail setting
□ Possible evidence of mental disorder (e.g. psychosis, depression)
□ Diagnosis (if known): _____
□ Other: _____

Brief summary of the presenting problem (required):

Requested by: □ Judicial Officer □ Law Enforcement □ Probation
□ Treatment Provider □ Jail Mental Health Staff □ Defense Attorney
□ Jail Corrections Staff □ Prosecuting Authority □ Other: _____

_____ _____
Requesting Party – Please Print Name Signature

_____ _____
Requesting Party Agency Phone/Email Contact

PLEASE ATTACH A FULLY COMPLETED AND SIGNED RELEASE OF INFORMATION

KITTITAS COUNTY UPPER AND LOWER DISTRICT COURTS
BEHAVIORAL HEALTH COURT

AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Name: _____ DOB: _____

I REQUEST AND AUTHORIZE the following agencies: (please initial)

_____ Kittitas County Prosecuting Attorney
_____ City of Cle Elum / Roslyn Prosecutor
_____ Kittitas County Misdemeanant Probation
_____ Kittitas County Jail
_____ Merit Resource Services
_____ Emergency Contact: _____
_____ _____

_____ City of Ellensburg Prosecutor
_____ Defense Representative: _____
_____ Kittitas County Sheriff's Department
_____ Comprehensive Healthcare
_____ Primary Care: _____
_____ _____
_____ _____

To RELEASE, COMMUNICATE, AND EXCHANGE THE FOLLOWING INFORMATION AND RECORDS REGARDING ME TO AND WITH THE BEHAVIORAL HEALTH COURT (BHC) and any of its participating BHC Team agencies and agents (please initial):

_____ My name, other personal identifying information, and my status as a participant in Kittitas County BHC.
_____ Medical Diagnosis and Treatment
_____ Substance Use Disorder Treatment: evaluation, testing, treatment plans, progress reports and discharge plans.
_____ All Mental Health Information: evaluation, testing, treatment, medications, treatment plans, progress reports and discharge plans.
_____ Criminal History _____ Custody records _____ Probation records
_____ Educational and school records _____ Other: _____

The above information will be used for the purpose of (a) providing referral information for determining my eligibility and suitability for participant in the Kittitas County Behavioral Health Court (BHC), (b) coordinating treatment services; (c) providing referral information; and (d) 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.

This information may, by implied or express authority from me, be disclosed to third parties as necessary in good faith for my referral to and/or participation in Behavioral Health Court. This authorization applies to all requested information you currently process and all future information you acquire within the time limits of this Authorization.

I understand I do not have to sign this authorization. I understand that my medical, mental health, and alcohol/substance use treatment records are otherwise protected and confidential under Federal and/or Washington State law including 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.

This authorization may be revoked at any time by providing notice in writing to the agencies listed above, except to the extent that action has already been taken in good faith reliance on it. However, I understand that this will result in my termination of eligibility and participation in BHC. Unless revoked by me, this Authorization is valid for 90 days for purposes of referral to the Kittitas County BHC and if accepted as a participant is valid until 90 days following the completion of my participation in BHC. I waive my right to a shorter duration of this Authorization.

Date: _____ Participant Signature: _____