Clark County Superior Court
Drug Court

1200 Franklin Street
PO Box 5000
Vancouver, WA 98666-5000
Tel. #(360) 397-2304

To Prescribing Physician/Psychiatrist/ Dentist / Other Prescriber:

Please note that your patient or prospective patient is a participant in one of the Clark County Superior Court Therapeutic Specialty Court programs (Drug Court/DOSA, Family Treatment Court, Juvenile Recovery Court). The program is designed for substance-abusing and court-involved persons. Therapeutic Specialty Courts provide participants with an opportunity to engage in an intense substance abuse program in the community with stringent reporting requirements to the courts.

If a current participant is prescribed any *potentially* addictive medication, we require that they have an **honest discussion** of their substance abuse/addiction history with you, leaving it to your discretion whether the medication to be prescribed or other alternative non-narcotic medication should be considered.

We hope that you or your representative will sign this letter and provide our program with a comprehensive list of medications being prescribed to our participant and acknowledge that the participant has discussed their substance use history with you.

If you have any questions, please contact Therapeutic Specialty Courts' Coordinator, Monday—Friday at (360) 397-2304.

Specialty Court Participant: _____ Date: _____

PLEASE LIST MEDICATION(s) BEING PRESCRIBED:

_____

_____

_____ _____

Prescriber signature *Date* *TSC Participant signature* *Date*

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:

I, _____, authorize Clark County Drug Court Program and _____
(Name of defendant) (Prescriber)
to communicate with and disclose to one another the following information:

_____ (Initial) my diagnosis, prescription, testing results, information related to client physical or mental health condition.

The purpose of the disclosure is to coordinate medical and treatment service. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically at the conclusion of Drug Court Participation:

Dated: _____ Signature of Patient _____