AUTHORIZATION AND CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL

I, ____, hereby consent to communication

between ____ and

____.

The purpose of and need for the communication and disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my treatment attendance, prognosis, compliance and progress in accordance with the referring court's monitoring criteria and ____.

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; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I also understand that I may revoke this authorization 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 as follows:

I understand this consent will remain in effect until:

_____ there has been a formal and effective termination or revocation of my release from confinement, probation, parole or other proceeding under which I was mandated into treatment, or

_____ ____.
(Specify other time when consent can be revoked and/or expires)

I understand that by revoking this authorization PRIOR to completion of my criminal justice referral requirements may affect my association with the criminal justice system.

I understand that authorizing the communication and disclosure of this health information is voluntary and that I may refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

______________________________ ______________________________
(Signature of Participant) (Date)

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.