

**CONSENT FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE ABUSE INFORMATION:
SOBRIETY/DRUG TREATMENT COURT REFERRAL**

I, _____, hereby consent to reciprocal communication between _____
(Name of Defendant) (Names of Treatment Providers)

_____ and
_____, _____, and Presiding Sobriety Court Judge, (Name
(Name of Treatment Provider) (Name of Treatment Provider)

County) County Prosecuting Attorneys' Office, Sobriety/Drug Court Defense Counsel, the Probation Department of (Name of County) County, and any and all substance use disorder assessment and treatment programs that have treated me and are participating in monitoring my progress in the sobriety/drug court program.

The purpose of, and need for, this disclosure is to inform the sobriety court and all other named parties of my eligibility and/or acceptability for substance use disorder treatment services, and my biopsychosocial assessment, my treatment attendance, prognosis, compliance and progress in accordance with the sobriety treatment court program's monitoring criteria.

I understand the substance use disorder treatment agencies herein that are covered entities (alcohol or other drug abuse treatment provider) are not conditioning treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

Disclosure of this confidential information may be made only as necessary for, and pertinent to, hearings and/or reports concerning _____
(List charges, docket number and indictment number). I understand that these disclosures may be made in open court.

I understand that my alcohol and/or treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C. F. R. Parts 160 & 164. 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 the event this authorization expires automatically as follows:

there has been a formal and effective termination of my involvement with the sobriety treatment court program for the above-referenced case, such as the discontinuation of all court-ordered probation supervision upon my successful completion of the sobriety treatment court requirements OR upon sentencing for violating the terms of my sobriety treatment court involvement.

I understand that by revoking this authorization PRIOR to completing the Sobriety/Drug treatment court program requirements will result in the sobriety/drug treatment court terminating me from the sobriety/drug court treatment program.

(Date)

(Name)

(Signature)

(Name of Witness)

(Signature of Witness)

(Signature of Interpreter where applicable)