GRANT COUNTY TREATMENT COURT

CONSENT FOR THE DISCLOSURE / RELEASE OF CONFIDENTIAL INFORMATION:

CRIMINAL JUSTICE SYSTEM REFERRAL

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that information regarding my eligibility for and participation in the Grant County Drug Court / Grant County OWI Court may be shared among any or all of the following:

1. The Treatment Court Team which includes: the Judge, the coordinator, Unified Community Services – treatment provider, representative from the Grant County District Attorney’s Office, representative from the Department of Corrections, representative from the Grant County Sheriff’s Department, and representative from the State Public Defender’s Office;
2. Treatment Court Interns;
3. Any and all law enforcement officers, including the Grant County Jail staff;
4. My criminal defense attorney, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;
5. Other treatment court participants and attendees;
6. Researchers and evaluators;
7. Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to the above communication. I understand the purpose of, and need for, this disclosure is to inform the Court and all other named groups and parties of my eligibility and/or acceptability for substance abuse treatment services, all my diagnoses (including, but not limited to, mental illness, substance abuse, and medical issues), AND my treatment attendance, prognosis, compliance and progress in accordance with the treatment court’s monitoring criteria. I understand that Treatment Court will receive written reports regarding the type of substance abuse treatment, amount of treatment and monthly cost of my treatment while I am a participant in Grant Court Drug Court / Grant County OWI Court. I understand that I will appear regularly in open court with other treatment court participants. I understand that docket entries may be made in the Circuit Court’s file that may reflect my participation and performance in Grant County Drug Court / Grant County OWI Court, and that these docket entries may be public record.

I understand that this consent will remain in effect from the date below until revoked by me. 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 as follows:

* There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.
* I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. It will remain in effect from the date below until revoked by me.

I recognize that my hearings are held in an open court and public courtroom, and it is possible that an observer could connect my identity with the fact that I am in treatment as a condition of participation in Drug Court / OWI Court. I specifically consent to this potential disclosure to third persons.

I also understand:

Any disclosure made is bound by the Code of Federal Regulations, 42 C.F.R. 2.11, 2.12, Section 290dd-2 governing confidentiality of alcohol and drug abuse patient records. Recipients of this information may re-disclose it only in connection with their official duties.

As stated in Code of Federal Regulations 42 C.F.R. 2.31, 2.35, as a participant in FDTC, I understand I have the right to revoke this release of information at any time. I further understand that revocation of my consent will result in immediate termination from the program.

The confidentiality of alcohol and drug abuse client records maintained by the treatment provider is protected by federal law and regulations. Generally, the treatment provider may not say to any person outside the program that a client attends the program or disclose any information identifying the client as an alcohol or drug abuser unless:

1. The client consents in writing;
2. The disclosure is allowed by a court order;
3. The disclosure is made to medical personnel for research, audit or program evaluation;
4. In the case of a medical emergency;
5. If a client commits a crime, or threatens to commit a crime, while enrolled in the treatment program; or
6. The client expresses suicidal or homicidal intent.

Violation of the federal law and regulations by the treatment provider is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state laws to appropriate state or local authorities.

I have been provided a copy of this form.

I acknowledge that I have a right to inspect and receive a copy of the material to be disclosed – as required under DHS 92.03(3)(d). I further acknowledge that I have been advised of my rights and have had the benefit of legal counsel or have voluntarily waived the right to an attorney. I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this Consent voluntarily.

Participant Date

Witness Date