

## AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION WITHIN COURT PROGRAMS

Legal Last Name First MI Date of Birth

Other Names used by Client/Applicant Case ID#

By signing this form, I authorize the following record holder (circuit court, agency, or medical or other provider) to disclose the following specific confidential information about me:

Release From	Specific Information to be Disclosed	Mutual Exchange: Yes/No
Lane County Mental Health DUII Program and/or Officers of the Court and/or	Presence in program, progress, UA results, treatment plan objectives, treatment concerns, discharge criteria, relapse prevention plan, fee payment status, program completion.	<b>YES</b>

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

Alcohol/Drug diagnoses, treatment, or referral

Release To (address required if mailed) If releasing to a staffing team, list staffing team members	Purpose	Expiration Date Or Event*
Quality Research Associates Evaluation Services, E. Miki Mace or designated representative 2802 Elysium Avenue Eugene, Oregon 97401 Fax: 541-485-0692 Phone: 541-343-0365	Report compliance/non/compliance with court ordered obligations for DUII, MIP, <oz. Marijuana, other alcohol or drug related court ordered offense monitoring.	

Identifying information that may include treatment status, where necessary, will be disclosed in the normal course of court proceedings open to the public, and I hereby authorize such disclosure.

I can revoke this authorization at any time. The revocation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to redisclosure and no longer protected under federal or state law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, or referral information.

Full Legal Signature of Individual <b>or</b> Authorized Personal Representative <b>X</b>	Relationship to Client <b>Self</b>	Date <b>X</b>
Full Legal Signature of Parent or Guardian- Required if Client is under 14	Relationship to Client	Date
Name of Staff Person (print) <b>X</b>	Initiating Agency Name/Location <b>X</b>	Date <b>X</b>

\*The authorization expires at separation from the program.

Full Legal Signature of Agency Staff Person Making Copies <b>X</b>	This is a true copy of the original Authorization document.
Print Staff Name	

## Important Information for the Client

**This is a Voluntary Form.** Your treatment provider may not condition treatment, payment, enrollment, or eligibility for the treatment provider's benefits on the provision of this authorization.

Participation in this court program requires your authorization for the treatment program to provide necessary information for the court program. This authorization form is used to obtain information to assess compliance and progress toward achieving treatment court objectives in your case. Refusal to sign or a decision to revoke the authorization will result in termination from the treatment court program.

**Disclosure:** This authorization for use and disclosure of information necessary to participate in the treatment court program. The information will be used by and disclosed to the people or programs listed on the authorization.

The information disclosed pursuant to this authorization may no longer be protected by the HIPAA Privacy Rules. For example, the judge and attorneys who receive the information are not subject to the HIPAA Privacy Rules, and information disclosed in the normal course of court proceedings will no longer be protected by the HIPAA Privacy Rules. But the federal regulations about substance abuse treatment records will continue to apply to the information, the extent required by those regulations.

Identifying information, where necessary, will be disclosed in the normal course of court proceedings open to the public, and I hereby authorize the same.

**Redisclosure:** After you authorize a disclosure of your substance abuse treatment records, federal regulations (42 CFR Part 2) prohibit the recipient of those records from redisclosing those records unless further disclosure is expressly permitted by your written authorization or by other provisions of the federal regulations. Also, if your records are disclosed to a covered entity under the HIPAA Privacy Rules, the covered entity may only redisclose your records with your written authorization or by other provisions of the HIPAA Privacy Rules. State law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly-funded programs (ORS 179.505, ORS 344.600) without specific written or oral authorization.

**Revocation:** Revocation will result in termination from the treatment court program.

### Using This Form

- 1. Terms Used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Staffing Team:** A number of individuals or agencies regularly working together. The agencies of which the staffing team members belong must be identified on this form.
- 2. Assistance:** When possible, your attorney should complete this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
- 3. Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
- 4. Revoke:** If you later want to revoke this authorization, contact the treatment court program coordinator. Revocation can be oral or in writing. Federal regulations do not require that the revocation be in writing for Drug and Alcohol Programs. No more information will be disclosed or requested after the authorization is revoked, except to the extent that action has been taken in reliance on it. Revocation will result in termination from the program.
- 5. Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
- 6. Special Attention:** For information about **HIV/AIDS, mental health, genetic testing, or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.
- 7. Relationship to Treatment Court Programs:** The treatment court is separate from the treatment programs and other services you may receive while in the program. Participation in this court program requires your authorization for the treatment program to provide necessary information for the court program. This authorization form is used to obtain information to assess compliance and progress toward achieving treatment court objectives in your case. Refusal to sign or a decision to revoke the authorization will result in termination from the treatment court program.