CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

(If multiple parties and/or agencies will be receiving this information, specify each party/agency below that will be receiving this information.)

I, _____, authorize

_____ to disclose to
(Provider of Confidential Information)

_____ Department of Social Services
(County name)
_____ Judicial District
(Court district number)
_____ Guardian ad Litem Program
(Court district number)

_____
(Other: List specific agency or person(s) or relationship)

_____
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_____
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the following information:

(Client needs to initial each category that applies.)

_____ my name and other personal identifying information
_____ substance abuse records
_____ mental health records
_____ assessment
_____ dates of services
_____ recommendations for treatment
_____ progress notes
_____ progress and compliance with treatment
_____ attendance
_____ date of discharge and discharge status
_____ discharge plan
_____ other _____

This otherwise confidential information will be used for the following purpose(s):
(**Client needs to initial each category that applies)**

_____ Monitor my progress or lack of progress in treatment.
_____ Provide appropriate services and referrals for me.
_____ Provide appropriate services and referrals for my family.
_____ Update my Treatment team of my progress or lack of progress in treatment.
_____ Update the Court and parties to my case about my progress or lack of progress in treatment.
_____ Other_____
_____

_____ Other_____
_____

For Substance Abuse Clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may revoke this consent at any time.

For Mental Health Clients**:** I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may revoke this consent at any time.

Protected Health Information:
I understand that my health information is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160& 164, but once this information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further redisclosure may occur. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on the consent.

I understand that generally _____
(Name of treatment program)
may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

If I do not revoke this consent, it expires automatically as follows:

1. Upon closure of my Protective Services/In-Home Services/Out of Home Services case; or
2. One year from the date this consent is signed; whichever occurs first.

_____ _____
Date signed Client's signature

_____ _____
Date signed Legally Responsible Person

_____ Client has received a copy of this consent form for his/her records.