GRIFFIN CIRCUIT ADULT FELONY DRUG ACCOUNTABILITY COURT

TREATMENT RELEASE OF INFORMATION AGREEMENT for TTG & Associates, LLC

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby authorize *Genna Marie Morris,* or any authorized contracted employee of **TTG & Associates** to **release, obtain or discuss** the following information:

* Results of Assessments (psychiatric, psychological and/or substance abuse/dependence information)
* Treatment Recommendation, Information, Plan or Progress
* Lab Results
* Medication use/prescriptions
* Suicidal, homicidal or psychotic thoughts, features, intent or actions
* Substance use/addiction history, relapse information or relapse prevention plans
* Compliance, behavior and attitude at group/individual treatment sessions
* Need for emergency treatment or emergency contact
* Court and/or treatment concerns/accomplishments
* DFCS or any other mandated agency

For the purpose of:

* Assessment & Recommendations
* Facilitation of Evaluation
* Coordination of Treatment
* Griffin Circuit Adult Felony Drug Court Contract for court-ordered treatment
* Safety Requirements or Mandated Reporter Requirements
* Other: Substance Abuse/Addiction Information specifically outlined according to state of Georgia

This information may be **obtained, released or discussed** with the following person(s) or agencies:

**\_\_\_\_\_\_\_All employees of the Griffin Circuit Adult Felony Drug Court Team, including Judge, Coordinators, Surveillance, Case Managers, Probation, District Attorney, Public Defender(s), Treatment Providers & Judge’s Assistant(s ) \_\_\_\_\_\_\_Any/all clinicians involved in your care at any facility, including jail/rehab centers. \_\_\_\_\_\_\_Your SO or closest Family Member Name/number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_Your Emergency Contact Name/Number (if diffferent from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Your Lawyer/number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Your Doctor(s) Names/numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand this release will be valid **for 1 year** unless I choose to revoke it through written notice and render myself ineligible for treatment in Griffin Circuit Adult Felony Drug Court. I understand that my court contract requires that I be honest and share all life information/events with my therapist(s).

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**Signature of Client**  Date

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Signature of Witness Date