IDAHO DEPARTMENT OF JUVENILE CORRECTIONS

COMMUNITY OPERATIONS and PROGRAMS SERVICES

Release of Information

Client Full Legal Name: _____ **Other Names Used:** _____

Date of Birth: _____ **IJOS/CMS/Other Case#:** _____

I, _____ *(name of client or of parent/guardian, if client is a minor)* authorize the (initial whichever parties apply)

_____Courts

_____SUDS Local Accountability Group (LAG) comprised of county and/or Tribal Probation Department personnel within the District or Tribal Committee.

_____SUDS Project Manager

_____Idaho Department of Correction

_____Idaho Department of Juvenile Corrections

_____Idaho Department of Health and Welfare

_____Prosecuting Attorney/s_____*(Name of prosecuting attorney)*

_____Public Defender/other defense counsel_____*(Name of criminal defense attorney)*

_____Misdemeanor and Juvenile Probation

_____Parents _____*(Name)*

_____Magellan

_____Medicaid

_____Treatment Provider (specify name of agency):_____

_____Other (specify):_____

to release, use, receive, mutually exchange, communicate with and disclose to one another the following information:

_____ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____ _____

The purpose of the disclosure is to inform any person, entity, or agency listed above of my attendance and progress in treatment.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information and/or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization:

HIV/AIDS _____ Mental Health _____ Alcohol/Drug _____ Genetic _____ STD _____ TB _____

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose of the release of information. I am signing this authorization of my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Although HIPPA requires that consents be revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until 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 also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

COMPLIANCE AND QUALITY ASSURANCE QUESTIONNAIRE

Please read and discuss all items and have client initial to indicate they have read and understood each statement.

_____1. I have clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns.

_____2. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to probation/parole, the judge and the prosecuting/deputy attorney.

_____3. I was given this release of information prior to beginning of treatment services.

_____4. I have read the summary of the confidentiality laws above.

_____5. I understand that this authorization will expire one year from the signed date of release unless on probation.

_____6. I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information.

_____7. I was provided a copy of the signed release of information.

Full Legal Signature of Client	Client	Date
Full Legal Signature of Parent or Legal Guardian – *Required if Client is a minor.*	Relationship to Client	Date
Name of Staff Person (print)	Initiating Agency Name/Location	Date

PROHIBITION ON REDISCLOSURE AND PROSECUTION: I understand that my alcohol and substance abuse treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2 and those recipients of this information may re-disclose it only in connection with their official duties. Federal rules limit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.