SANTA CLARA COUNTY CRIMINAL JUSTICE REFERRAL
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____ (print name of client), authorize the following alcohol and other drug (AOD) treatment agencies:

All County and private providers of AOD services;

To disclose to the following criminal justice agencies:

Superior Court (including Drug Treatment Court); Adult Probation Department; my defense attorney(s); District Attorney's Office; Office of Pre-Trial Services; State Parole, Department of Correction; Adult Custody Health Services; Office of the Sheriff and Office of Re-Entry Services

the following information:

All information obtained during the course of my participation in AOD services which is necessary to monitor my participation in, and compliance with, treatment including assessments, treatment plans, treatment status (admission, participation, cooperation, progress, completion, termination), and drug testing information.

The purpose of this exchange of information is to inform the criminal justice agencies of my eligibility for, enrollment in, attendance at, and progress in completing AOD treatment ordered by the Court.

I understand that my AOD treatment records are protected under Federal Regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written authorization unless otherwise provided for by regulation. The exceptions are set forth in the Department of Alcohol and Drug Services (DADS) Notice of Privacy Practices for County programs and in the privacy notices of private programs where I received services.

I understand that this authorization is revocable only when there has been a final disposition or formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceedings under which I was mandated by the Court into AOD treatment.

This authorization expires on the date that my participation in the Court mandated drug treatment program terminates.

I understand that generally AOD treatment programs may not condition the provision of treatment to me on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

Client Signature: _____ Date: _____
Client, guardian, or representative where required: _____

I have received a copy of this authorization. _____
Signature of client

NOTE TO RECIPIENT: Federal Regulation prohibits further disclosure of this information without specific written authorization from the person to whom this information pertains or as otherwise expressly permitted by 42 C.F.R. part 2. A general authorization for medical or other information is not sufficient for this purpose. However, a person who receives information pursuant to this authorization may redisclose and use it to carry out that person's official duties with regard to the participation in the Court mandated drug treatment program by the person signing this authorization.