**AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE ABUSE INFORMATION: 7th JUDICIAL DISTRICT COURT REFERRAL**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize communication, both written and verbal between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The purpose of, and need for, this disclosure is to inform the court and all other named parties of my eligibility and/or acceptability for substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the probation requirements. The type and extent of the information to be disclosed will include only that information which is necessary for, and pertinent to, the 7th Judicial District Courts monitoring criteria in connection with the case/charges of Case #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that such information, where necessary, will be disclosed in open-court, which is a public forum, and I hereby authorize the same. I understand that failure to complete the probation requirements may result in re-sentencing on Case #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that my termination from ATC Court may be used as a basis to revoke my sentence and for re-sentencing but that the prosecutor will not use my ATC Court records in open court or revocation of probation or re-sentencing unless I raise issues about my termination from ATC Court at the hearing.

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations. I also understand that recipients of this information may re-disclose it only on connection with their official duties.

I also understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program

I understand that covered entity (alcohol or other drug abuse treatment provider) is not conditioning treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization will expire automatically when there has been a formal and effective termination of my involvement with probation for the above-referenced case, such as the discontinuation of all court (all/or, where relevant, probation) supervision upon my successful completion of the probation requirements, OR upon sentencing, after termination from probation.

I understand that if I revoke this authorization prior to successful completion of all requirements of probation, it may result in the termination from probation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Defendant/Probationer

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Signature of Defendant/Probationer Witness Signature

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_