CONSENT FOR THE RELEASES OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, ________________________ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County** to have reciprocal verbal communication and to exchange written records with:

☐ Other: ____

		I **DO** GIVE CONSENT (Initial line)			I **DO** GIVE CONSENT (Initial line)
1.	Addiction Severity Index (ASI) Assessment	________	10.	Psychiatric or Psychological Progress Reports	________
2.	Bio-Psycho-Social Assessment	________	11.	Summary Diagnosis	________
3.	Current Medications	________	12.	Current Symptoms and Treatment Plan	________
4.	Result of Psychological Evaluation(s)	________	13.	Statement of Treatment Prognosis	________
5.	Discharge Summary	________	14.	Statement of Treatment Status/Progress	________
6.	Medical and Physical Examination Results	________	15.	Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	________
7.	Other Medical Results	________	16.	Employment	________
8.	Admissions/Intake Summary	________	17.	________________________	________
9.	Program Attendance (session, type, frequency)	________			

I UNDERSTAND (Initial line)

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment. ________
2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force for one (1) year. ________
3. I understand that my continued participation in the Grafton County Drug Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider. ________
4. I understand that I will be asked to renew this consent, at a minimum, on an annual basis, throughout the course of my participating in the Grafton County Drug Court Sentencing Program. ________
5. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations. ________

________________________________ ________________________
Participant's Signature Date

________________________________ ________________________
Signature of Witness Date

____
Name & Title of Witness (PRINTED)