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Authorization for Use/Disclosure of Protected Information—Criminal Justice System Referral

This form is to confirm your authorization to use/disclose your protected health information. This release of information is for the purpose of counseling and related treatment.

Client: _____ **DOB:** _____ **Date:** _____
(Print name of defendant)

Client Address: _____

If under 18 years old, Parent/guardian printed name: _____ DOB: _____

The purpose of and need for the disclosure is to inform the criminal justice agency (ies) listed below of my **attendance and progress in treatment.** The extent of information to be disclosed is my **diagnosis, information about my attendance or lack *of attendance at treatment sessions, my cooperation with the treatment program, prognosis and:***

_____

Agency and/or Person: _____

Address: _____

Phone: _____ Phone: _____ Fax: _____

I understand that this consent 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.

Or: _____
(Other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of title 42 of the code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

_____ _____
Signature of defendant/client of Stone City Counseling, Inc. Date

_____ _____
Signature of parent, guardian or authorized representative Date

_____
Printed name of parent, guardian or authorized representative

_____ _____
Witness signature Date