HIPPA RELEASE FORM

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL INFORMATION TO THE BUTTE SILVER BOW DUI COURT

I, _____, authorize the Butte Silver-Bow
(Name of Patient and Social Security #)
DUI Court and the following:

(1) Any alcohol or drug treatment programs or providers that have provided me services since _____, (Date)

(2) My medical care provider(s) at _Butte Silver Bow Health Dept
(Name of Physician or Agency Provider)

(3) Any of the following members of the Justice Court team, inclusive of my Public Defender/Legal Counsel; County Attorney's Office; Justice Court, Local Police Department and Sheriff's Department, Job Service.

To communicate with and disclose to one another the following information: (Nature and amount of the information as limited as possible)

(Initial each category that applies)

_____my name and other personal identifying information;

_____my status as a patient in (alcohol or drug and mental health) treatment;

_____initial and subsequent evaluations of my service needs by the CDTC and its members;

_____summaries of alcohol/drug and mental health assessment results and history;

_____summary of alcohol/drug treatment and mental health services plan(s), progress and compliance;

_____attendance in alcohol/drug treatment and mental health services;

_____discharge plan(s) for alcohol/drug treatment and mental health services;

_____date of discharge from alcohol/drug treatment and mental health services, discharge status and follow-up recommendations;

_____academic performance, school attendances and school behaviors and consequences of my children that are involved with Family Treatment Court

_____other:

The purpose of the disclosures authorized in this consent is to enable Butte DUI Court and its members to evaluate my need for services from Butte Health Dept. and its members, and provide and coordinate DUI and its members' services to me.

I understand that my alcohol drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records. 42CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. I also understand that should I choose to revoke this consent, my agreement with the Court to participate in, and complete all requirements of DUI Court, will be null and void. In the event that I do not revoke my consent, this consent expires automatically 6 months following my successful completion of DUI COURT

_____

Patient Signature Date

_____

Witness Signature Date

Cc:
DUI Team
Center for Mental Health
Silver-Bow County Attorney's Office
Public Defender's Office
Butte-Silver Bow County Sheriff's Office
Parole and Probation
Health Dept.