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Client Name_____Client Number_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL
42 CFR Part 2 and HIPAA

I, _____, authorize _____ to disclose to one another:
[Patient's Name] *[Name or general designation of individual or entity making the disclosure]*

Initial in box for all that apply:

☐NC Department of Community Corrections (PO): _____ ☐NC DMV _County of Arrest?_____
☐NC Division of MH/DD/SAS (DWI Services) _____ ☐_____ *[District Attorney]*
☐ _Atty?_____ (*Criminal Defense Attorney)* ☐ _____ *[Name of the appropriate court]*
☐ Providers_____ *(Other)* the following information:
☐ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and/or
☐ ___Assessment Recommendation *[describe how much/what kind of information may be disclosed including explicit description of what SUD information may be disclosed; as limited as possible]* for the purpose of Court Compliance.
[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: One Year upon Compliance. *[describe date/event/ condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]*

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____
Signature of Patient

Dated: _____
Signature of person signing form if not patient

Dated: _____
describe authority to sign on behalf of patient

Dated: _____
Witness/Staff Signature

Notice Prohibiting re-disclosure of Substance Use Disorder Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.