

**Beaver County
Treatment Court Release
Consent to Release Confidential Information**

Client Name _____

DOB _____

Address _____

Phone # _____

I (client) give my consent to the following:

- | | |
|--|--|
| ☐ Beaver County Drug & Alcohol | ☐ Beaver County Public Defender's Office |
| ☐ BCBH Mental Health Unit | ☐ Beaver County Treatment Court Coordinator |
| ☐ Beaver County Courts | ☐ Beaver County District Attorney |
| ☐ Beaver County Adult Probation | |

To communicate with and disclose to one another the following information:

- ☐ Verbal information regarding the coordination of services for Beaver County Treatment Court
- ☐ Other _____

Reason for Disclosure:

- ☐ For agencies indicated above to coordinate services for Beaver County Treatment Court at the request of client
- ☐ Other _____

This authorization expires as indicated (if no indication is provided, authorization will be in effect for 365 days).

☐ Specify date or event _____

I understand that:

- I have the right to revoke this authorization at any time in writing. However, the revocation of this authorization will not affect the disclosure of any information that has already been sent to the individuals/organizations listed above.
- In accordance with 4 PA code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plans, or governmental officials shall be restricted to the following: (1) Whether the client is or is not in treatment, (2) The prognosis of the client, (3) The nature of the program, (4) A brief description of the progress of the client, (5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- The agencies listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I am entitled to a copy of this completed authorization form.

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- Continued -**

PART B

Drug & Alcohol information will be disclosed as protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Mental Health and HIV/AIDS information will be disclosed as protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

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I have been offered a copy of this form and I have: ☐Accepted ☐Refused

Signature of Client/Legal Representative

Date

Signature of Staff/Witness Representative

Date

REVOCATION STATEMENT:

I, _____ have REVOKED this consent

on _____