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DIRECTOR



SUBSTANCE ABUSE PREVENTION AND
RECOVERY INDIGENT SERVICES

UTAH COUNTY DIVISION OF SUBSTANCE ABUSE

.....a Division of the Utah County Health Department

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PERMISSION TO SHARE CONFIDENTIAL INFORMATION WITH THE CRIMINAL JUSTICE SYSTEM

Name: _____ DOB: _____ CT ID: _____

I give my permission for Utah County Division of Substance Abuse staff and the following agencies, programs, and providers to share appropriate information (initial applicable criminal justice agency(ies):

<u>Agency</u>	<u>Client's Initials</u>
Department of Corrections (AP&P)	_____
Utah State District Court: _____	_____
Utah County Justice Court: _____	_____
Utah County Attorney's Office	_____
Utah State Juvenile Court	_____
Utah County Juvenile Multi-Agency Staff Team	_____
Division of Juvenile Justice Services	_____
Utah County Jail	_____
Utah State Public Safety Department (DMV)	_____
Argus	_____
_____	_____
(Other Criminal Justice Agency)	

The extent of the information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, drug test results, my cooperation with the treatment program and prognosis. 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. I understand that data derived from my participation in my treatment may be used for research purposes, so long as my anonymity is maintained in accordance with the Federal, State and professional research standards.

I also understand that any disclosure made by and through this permission is bound by (HIPAA) 45 CFR 160 - 164 and Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse clients records and that recipients of this information may redisclose it only in connection with their official duties.

This consent is valid until: **Treatment is completed and court case is closed + sixty days.**

Signature: _____ Date: _____

Witness: _____ Date: _____

Signature of Parent or Guardian: _____ (If Applicable)

NOTICE: YOU (THE CLIENT) SHOULD OBTAIN A COPY OF THIS RELEASE UPON SIGNING STAFF DO NOT LEAVE ANY BLANK LINES IN THIS DOCUMENT

NOTICE: This electronic communication may contain protected health information, the release of which is restricted by federal law. Any information about a client or clients has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The federal rules prohibit you 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 C.F.R., Part 2, and HIPAA. A general authorization 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 client. Any unauthorized redisclosure of the information contained in this communication may be punishable under federal statutes.