WASHINGTON COUNTY
COURT SUPPORT SERVICES

Consent to Release Information

Last Name _____ First Name _____ SS # _____ Birth Date _____

Former Name(s) _____ Home # _____ Work # _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION IS HEREBY GRANTED TO RECEIVE OR RELEASE INFORMATION TO/FROM:

Person/Agency Name _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

TO RELEASE THE FOLLOWING INFORMATION (including Substance Use Disorder [SUD] Information

- ☐ All Records, including SUD
- ☐ Evaluation/Mental Status
- ☐ Evaluation/Mental Status, including SUD
- ☐ Recovery Plan /Treatment Plan
- ☐ Recovery Plan, including SUD
- ☐ Progress Reports
- ☐ Progress Reports, including SUD
- ☐ Discharge Reports
- ☐ Discharge Reports, including SUD
- ☐ Medication Information
- ☐ Medication Information, including SUD
- ☐ Psychiatric/Psychological Evaluation
- ☐ UA Results
- ☐ Lab Reports
- ☐ Court Ordered Attendance/Treatment Compliance
- ☐ Other (*Describe)*

_____

_____

Date Range of Information to be released (if applicable) _____

I understand this information is being requested for the purpose of _____

I authorize the individuals/entities listed below to receive or release my medical, mental health, and/or substance abuse disorder treatment records to Washington County Court Support Services:

Person/Affiliation _____ Phone # _____ Fax # _____

Address _____ City _____ State _____ Zip _____

Person/Affiliation _____ Phone # _____ Fax # _____

Address _____ City _____ State _____ Zip _____

Person/Affiliation _____ Phone # _____ Fax # _____

Address _____ City _____ State _____ Zip _____

Person/Affiliation _____ Phone # _____ Fax # _____

Address City State Zip

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition or, if not specified, this release will expire 90 days after client's services are terminated.

EXPIRES: Date _____ -OR- Event _____ -OR- Condition _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Washington County Court Support Services cannot guarantee this person/agency will not re-disclose your records. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

SIGNATURES:

Client Signature _____ Date _____

Printed Name of Authorized Representative _____ Relationship _____

Address of Authorized Representative _____ Phone # _____

Staff Member/Witness Signature _____ Date _____

NOTICE: To Accompany Release of Alcohol and Drug Abuse Records

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). 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 42CFR part 2. A general authorization for the release of medical or other 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 patients.

Form updated 8/6/18