# WASHINGTON COUNTY VETERANS TREATMENT COURT

## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Advisement: This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By signing this form, I, (_____), or my authorized representative, consent to and authorize the Washington County Veterans Treatment Court ("Program") and the following individuals and entities listed below to disclose my information and communicate with one another regarding my eligibility and/or acceptability for the Program, to monitor my progress in and compliance with substance abuse and/or mental health treatment services, and to monitor my compliance with Program requirements and directives. This includes sharing with each other my assessment results, diagnostic conclusions, prescribed medications, unprescribed substance use, screening results, referrals to treatment and other services, treatment attendance records, progress in treatment, compliance with treatment, and compliance with Program requirements and directives. My information may also be disclosed in connection with an audit or evaluation of the performance of the Program and to determine whether the Program is following best practices such as the Oregon Specialty Court Standards.

I understand that my alcohol, drug, and/or mental health treatment records are protected under applicable state and federal law and regulations including, without limitation, ORS 3.450, the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 C.F.R. Parts 160 & 164.

This disclosure is not intended to apply to confidential legal communications I have with my lawyer, or with the defense counsel named below. I verify that I have read and understand this (initial here) _____.

□ Washington County Circuit Court

□ Program Coordinator

□Veteran Mentor Coordinator

□ Department of Veterans Affairs, Portland VA Healthcare System

□ Harris Velázquez Gibbens, Attorneys at Law

□ Washington County District Attorney's Office

□Washington County Community Corrections Department

□ Washington County Sheriff's Office

□ Washington County Aging, Disability and Veteran Services

□ Solutions Group NW

□ LCN Wellness

□ Cedar Counseling Center

□ The Salvation Army Veteran and Family Center (VFC)

I understand that I have no legal right to participate in the Program and that this consent is required in order to participate in this Program. This consent form is used to obtain information to assess my compliance and progress toward achieving the Program's objectives. The Program is separate from treatment programs and other services I may receive while in the Program.

I understand that my treatment provider may not condition treatment, payment, enrollment, or eligibility for the treatment provider's benefits on the provision of this consent.

If I sign this consent my information will be disclosed to the people or programs listed on this form. The information disclosed to an entity covered under the HIPAA Privacy Rules may only be redisclosed with my written authorization or under other provisions of the HIPAA Privacy Rules. Information disclosed pursuant to this authorization may no longer be protected by the HIPAA Privacy Rules if it is disclosed to people or programs that are not subject to the HIPAA Privacy Rules. For example, the judge and attorneys who receive the information are not subject to the HIPAA Privacy Rules. However, the other federal regulations that protect my information will continue to apply. If my information is disclosed to a person or entity not covered by the HIPAA Privacy Rules, that person or entity may only redisclose my records with my written authorization or under other provisions of the federal regulations.

Identifying information including treatment status and compliance with Program requirements may be disclosed in the normal course of court proceedings open to the public and recorded in court data information systems available to the public, and I hereby authorize such disclosure. I understand that it is possible that an observer could make the connection between specialty court participation and substance abuse and/or mental health treatment. I understand that information disclosed during court proceedings will no longer be protected by the HIPAA Privacy Rules.

I understand that my treatment records and other treatment related information cannot be used to investigate, initiate, substantiate criminal charges against me. However, federal laws and regulations do not protect information related to the commission of a crime, or any threat to commit a crime, while on Program premises or against Program personnel. Additionally, federal laws and regulations do not protect information related to suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I understand that I may revoke this consent at any time. I understand that this consent agreement is a condition of the Program and if I revoke my consent I will be terminated from the Program. Revoking my consent will not affect any information that was previously disclosed.

This consent will expire upon my completion of, or separation from, the Program, or upon the determination that I am not entering the Program.

Any violation of federal law and regulations is a crime and suspected violations may be reported to the U.S. Attorney for Oregon (see https://www.justice.gov/usao-or/our-locations) or the Substance Abuse and Mental Health Services Administration (SAMHSA)( see https://www.samhsa.gov/about-us/contact-us). You may sign this Consent using either: (i) an original signature on a printed document; or (ii) an electronic signature. If using an electronic signature, you may electronically sign either by typing "s/" followed by your name (example: s/ John Doe) or by using electronic signature software that includes a Security Procedure (defined in ORS 84.004) designed to verify your electronic signature.

**I have read and understand the contents of this consent. I fully understand my rights and I am signing this consent voluntarily. I understand that, by signing this consent form, I am authorizing disclosure of my protected health information, as outlined above, to the persons and/or entities listed on this form. I further understand that this consent will be in effect for the duration of time I am in the Program, or until the determination that I am not entering the Program. I am not under the influence of drugs or alcohol.**

Printed Name: _____

Signature: _____ Date: _____

Witness Name: _____ Position: _____

Witness Signature: _____ Date: _____