

IDAHO DEPARTMENT OF JUVENILE CORRECTIONS  
**JUVENILE JUSTICE SUBSTANCE USE DISORDER**  
Release of Information

**Client Full Legal Name:** \_\_\_\_\_ **Other Names Used:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **IJOS/CMS/Other Case#:** \_\_\_\_\_

I, \_\_\_\_\_ authorize (initial whichever parties apply)

\_\_\_\_\_ Courts

\_\_\_\_\_ SUDS Local Accountability Group (LAG) comprised of county and/or Tribal Probation Department personnel within the District or Tribal Committee.

\_\_\_\_\_ SUDS Project Manager

\_\_\_\_\_ Idaho Department of Correction

\_\_\_\_\_ Idaho Department of Juvenile Corrections

\_\_\_\_\_ Idaho Department of Health and Welfare

\_\_\_\_\_ Prosecuting Attorney/s \_\_\_\_\_ (Name of prosecuting attorney)

\_\_\_\_\_ Public Defender/other defense counsel \_\_\_\_\_ (Name of criminal defense attorney)

\_\_\_\_\_ Misdemeanor and Juvenile Probation

\_\_\_\_\_ Parents (if a juvenile) \_\_\_\_\_ (Name)

\_\_\_\_\_ Business Psychology Associates (BPA)

\_\_\_\_\_ Medicaid/Optum

\_\_\_\_\_ Treatment Provider (specify name of agency): \_\_\_\_\_

\_\_\_\_\_ Other (specify): \_\_\_\_\_

to release, use, receive, mutually exchange, communicate with and disclose to one another 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

\_\_\_\_\_

The purpose of the disclosure is to inform any person, entity, or agency listed above of my attendance and progress in treatment.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information and/or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization:

HIV/AIDS \_\_\_\_\_ Mental Health \_\_\_\_\_ Alcohol/Drug \_\_\_\_\_ Genetic \_\_\_\_\_ STD \_\_\_\_\_ TB \_\_\_\_\_

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose of the release of information. I am signing this authorization of my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

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I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Although HIPAA requires that consents be revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization 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 also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

**COMPLIANCE AND QUALITY ASSURANCE QUESTIONNAIRE**

*Please read and discuss all items and have client initial as they have read and understood each statement.*

- \_\_\_\_ 1. I have clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns.
- \_\_\_\_ 2. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to probation/parole, the judge and the prosecuting/deputy attorney.
- \_\_\_\_ 3. I was given this release of information prior to beginning of treatment services.
- \_\_\_\_ 4. I have read the summary of the confidentiality laws above.
- \_\_\_\_ 5. I understand that this authorization will expire one year from the signed date of release unless on probation.
- \_\_\_\_ 6. I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information.
- \_\_\_\_ 7. I was provided a copy of the signed release of information.

Full Legal Signature of Client <i>or Authorized Personal Representative</i>		Relationship to Client	Date
Full Legal Signature of Parent or Legal Guardian – <i>Required if Client is under 16 years of age, but only after signed by Client.</i>		Relationship to Client	Date
Name of Staff Person (print)	Initiating Agency Name/Location		Date

**PROHIBITION ON REDISCLOSURE AND PROSECUTION:** I understand that my alcohol and substance abuse treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2 and those recipients of this information may re-disclose it only in connection with their official duties. Federal rules limit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.