



CONSENT FOR THE RELEASES OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)

of the **Drug Treatment Court (DTC) Sentencing Program for Grafton County, to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

Other: _____

	I DO GIVE CONSENT (Initial line)		I DO GIVE CONSENT (Initial line)
1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

- | | I UNDERSTAND
(Initial line) |
|---|---------------------------------------|
| 1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment. | _____ |
| 2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force until the day I graduate from Drug Court Sentencing Program or the day I am terminated from the Drug Court Sentencing Program. | _____ |
| 3. I understand that my continued participation in the Grafton County Drug Court Sentencing Program is conditioned upon ongoing communication between the court and my treatment provider. | _____ |
| 4. I understand that I may be asked to renew this consent, throughout the course of my participating in the Grafton County Drug Court Sentencing Program. | _____ |
| 5. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations. | _____ |

Participant's Signature

Date

Signature of Witness

Date

Name & Title of Witness (PRINTED)