

COR Plus
Authorization for Release of Substance Use Disorder Patient Records
Criminal Justice Referral

Case Number: _____ District: _____ County: _____

I, _____ (Name of Patient), (date of birth), hereby give Community Oriented Recovery Plus, LLC and its affiliates, subsidiaries, parent companies, employees and agents (collectively "COR Plus") consent to release my substance use disorder patient records to the following:

Judge: _____ Probation/Parole Authority(Office/Dept): _____

Defense Attorney: _____ Prosecuting Attorney: _____

Parent (if Patient is a Juvenile and the charge is a DUI/DWAI/MIP, etc.): _____

Other (Person who has a duty to monitor treatment in connection with the disposition of the case) _____

The purpose of and need for the disclosure is to inform the individuals or entities listed above of my attendance and progress in treatment, or

Other reason for disclosure: _____

The extent of information to be disclosed is:

Name Information Diagnosis Information Clinical Termination Data Referral Information
 Attendance Data Medical History/Exam Data Clinical Progress Data
 Drug & Alcohol Testing Results Other (Specify) _____

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 other proceeding under which I was mandated into treatment; **or**

Other: _____
(Specify other time when consent can be revoked and/or expires)

I understand that copies of this form may be used in place of the original.

I understand that my substance use disorder patient records are protected by federal law and regulations, specifically 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2, and may also be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it only in connection with their official duties.

I understand that generally COR Plus may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to Defendant: _____

Witness: _____ Date: _____

PROHIBITION ON REDISCLOSURE
NOTICE: 42 CFR part 2 prohibits unauthorized disclosure of these records.

Notice of Federal Requirements Regarding the Confidentiality of Substance Use Disorder Patient Records

The confidentiality of substance use disorder patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as having or having had a substance use disorder unless:

1. The patient consents in writing; or
2. The disclosure is mandated by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program,

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(See 42 U.S.C. §290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.)