32nd Judical District Mental Health Court
Justice Center: 29 West Main Street Hohenwald, TN 38462
Phone: 931-231-8343 Cell: 931-628-3099 Fax: 931-295-3504

Authorization for Release of Information

Name _____ DOB _____ Social Security # _____

I hereby authorize the release of the following specific information:

YES	NO	(All items must be checked yes or no)
___	___	1. Medical history, examination, lab tests and treatment reports
___	___	2. Psychological test reports
___	___	3. Psychiatric evaluation reports
___	___	4. Social history, including family, education, employment, arrest and substance use history
___	___	5. Summary of previous mental health and/or A & D treatment
___	___	6. Periodic reports of current treatment progress, including attendance, participation & drug Screen results
___	___	7. Verification of admission/discharge
___	___	8. Other (specify)_____

FROM/TO:
32nd Judicial District
Mental Health Court

FROM/**TO**:
NAME:_____
AGENCY:_____

ADDRESS:_____
_____
PHONE:_____FAX:_____

Authorization valid ☐Any and all Records ☐date range: From: _____ To: _____

I understand that this information will be used for the following purposes:

YES	NO	(all items must be checked yes or no)
___	___	1. To develop a diagnosis, treatment and/or rehabilitation plan
___	___	2. To coordinate medical, psychological, and social services
___	___	3. To determine present and future eligibility for probation, parole, bail bond, pre-trial release or other diversion process within the criminal Justice system
___	___	4. To advise family and/or referring agency/party of treatment process
___	___	5. Other (specify):_____

I understand that this information may be released in the following forms:
__Verbal __Written __Fax __Scan/Email __Other (specify)_____

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2 ("Part 2") and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time that action has been taken in reliance on it, and that in any event this consent expires after _____.

Or under the following conditions_____
I understand that generally the 32nd Judicial District Mental Health Court program does 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. I also acknowledge that I was given a copy of this release.

_____ _____
Participant Signature Date

_____ _____
Witness Signature Date