ATTENTION:

<u>Attorneys and Probation Officers</u>

If you are giving this application to a potential Problem Solving Court Participant, make sure that they understand the release of information and initial and sign all of the sections as directed.

<u>Applicant:</u>

The following release of information gives the Problem Solving Courts permission to share protected confidential information with multiple parties as indicated on the release of information. Make sure you are aware of the potential disclosure of your information.

Problem Solving Court Description

You are not eligible for admission into a Problem-Solving-Court (PSC) if you have not been convicted or plead guilty and sentenced for your crime(s). If you are applying to a PSC and have not been sentenced you will not be admitted into that PSC prior to your sentencing.

District 7 Problem Solving Courts are intensely structured programs that promote recovery and self sufficiency. These programs are phase based, requiring the participant to successfully complete 4 phases of the program. All phases are completed by developing competencies that promote recovery and self-sufficiency.

The Problem Solving Courts integrate treatment for mental health, substance use and criminogenic risks; using manualized, evidence based models that treat individual needs. There is an emphasis on employment, education and other productive activities.

Intense supervision is a part of all the Problem Solving Courts and requires daily call-ins and frequent and random substance use testing which is directly observed by program staff.

The participant is required to attend all assigned treatment activities, comply with supervision, and attend status hearings on a regular basis with the presiding Judge. Participants will also pay a monthly Problem Solving Court fee in addition to their court fines and cost of supervision.

Once you are accepted into a Problem Solving Court you will receive a specific handbook regarding that programs outline as well as expected terms and conditions of supervision.

ATTENTION: MAKE SURE YOU COMPLETE THE ENTIRE APPLICATION. IF A SECTION DOES NOT APPLY THEN WRITE (D/N/A) IN THE MARGIN. IF YOU DO NOT KNOW THEN WRITE (DK) IN THE MARGIN. Failure to complete the entire application will delay your application process and may result in denial.

Seventh Judicial District Problem Solving Court

CLIENT RIGHTS

The Seventh Judicial District Problem Solving Court programs agree to protect your fundamental human, civil, constitutional and statutory rights.

Your Rights Include but are not limited to the following:

a. The right to impartial access to treatment, regardless of race, religion, gender, ethnicity, age or handicap.
b. Respect for personal dignity in the provision of all care and treatment.
c. The right to adequate and humane services, regardless of the source of financial support.
d. The right to receive services within the least restrictive environment possible.
e. The right to an individualized treatment plan, based on assessment of current needs.
f. The right to participate in planning for treatment.
g. The right to request Department of Health and Welfare staff to review the treatment plan or the services provided.

By signing below, I acknowledge that I have been informed of my rights as a Problem Solving Court client.

_____ _____

Clients Signature Date

SEVENTH JUDICIAL DISTRICT
PROBLEM SOLVING COURTS

Notice of Privacy Practices and Confidentiality of Alcohol and Drug Abuse Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

If you have any questions about this notice, please contact us by telephone during business hours or in writing:

Privacy Officer: Rex Thornley
Problem Solving Court Treatment Program
605 N. Capital Ave.
Idaho Falls, ID 83402
208-705-5071

Effective Date: ***March 13, 2008***

Health information which we receive and/or create about you, personally, in this program, relating to your past, present, or future health, treatment, or payment for health care services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by another Federal law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally, the program may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal law. Your health information is further protected by any pertinent state law that is more protective or stringent then either of these two Federal laws.

This Notice describes how we protect personal health information (otherwise referred to as "protected health information") we have about you, and how we may use and disclose this information. This Notice also describes your rights with respect to protected health information and how you can exercise those rights.

Uses and disclosures that may be made of your health information:

• **Internal Communications:** Your protected health information will be used within our program, that is between and among program staff who have a need for the information.

Information may also be shared and among our program and the Department of Health and Welfare, and Business Psychology Associates and their contracted providers in connection with our duty to diagnose, treat, or refer you for substance abuse treatment. This means that your protected health information may be shared between or among personnel for treatment, payment or health care operation purposes. For example: Two or more providers within the program may consult with each other regarding your best course of treatment. The program and the County Clerk's office may share your protected health information with the Department of Health and Welfare and Business Psychology Associates and other billing sources in a billing effort to receive payment for health care services rendered to you. And/or, your protected health information may be discussed within the program about your treatment in connection with others in the program, in an effort to improve the overall quality of care provided by our program. Your protected health information will not be redisclosed by program personnel and/or the Department of Health and Welfare, and Business Psychology Associates, except as is otherwise permitted herein.

• **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of this program, that assist our program in providing health care. Examples of qualified service organizations and/or business associates include billing companies, data processing companies, or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this program through terms detailed in a written agreement.

• **Medical Emergencies:** Your health information may be disclosed to medical personnel in a medical emergency, when there is immediate threat to the health of an individual, and when immediate medical intervention is required.

• **To Researchers:** Under certain circumstances, this office may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one test or treatment to those who received another, for the same condition. All research projects, however, must be approved by an Institutional Review Board, or other privacy review board as permitted within the regulations, that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

• **To Auditors and Evaluators:** This program may disclose protected health information to regulatory agencies, funders, third-party payers, and peer review organizations that monitor alcohol and drug programs to ensure that the program is complying with regulatory mandates and is properly accounting for and disbursing funds received.

• **Authorizing Court Order:** This program may disclose your protected health information pursuant to an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determinations as outlined in the Federal regulations and limits the scope of the disclosure.

• **Crime on Program Premises or Against Program Personnel:** This program may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the program premises or against program personnel.

• **Reporting Suspected Child Abuse and Neglect:** This program may report suspected child abuse or neglect as mandated by state law.

• **As Required By Law:** This program will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

• **Appointment Reminders:** This program reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

• **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice, will be made only with your written authorization or that of your legal representative. If you or your legal representative authorize us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on the authorization.

Your rights regarding protected health information we maintain about you:

• **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit your request in writing to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing, or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial to any part or parts of your request. Some denials, by law, are reviewable, and you will be notified regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in the law, are not reviewable. Each request will be reviewed individually, and a response will be provided to you in accordance with the law.

• **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for us; or

- Is not part of the protected health information which you would be permitted to inspect and copy.

If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial and/or how you may request that your request to amend and a copy of the denial be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.

• **Right to an Accounting of Disclosures:** You have the right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment, or health care operations within our program and/or between our program and the Madison County Clerks office, the administrative boards and committees of Seventh Judicial District Drug Court, the Department of Health and Welfare, Business Psychology Associates and their contracted providers, or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions:** You have the right to request a restriction or limitation on protected health information we are permitted to use or disclose about you for treatment, payment or health care operations within our program and/or between our program and the Madison County Clerks office, the administrative boards and committees of the Seventh Judicial District Drug Court, the Department of Health and Welfare, and Business Psychology Associates. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your health.

• **Right to Request Confidential Communications:** You have the right to request that we communicate with you about protected health information in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services at:

OFFICE FOR CIVIL RIGHTS
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D. C. 20201
Telephone: 866-627-7748 - TTY: 886-788-4989 - email:
www.hh.gov/ocr

To file a complaint with this office, please contact:

Privacy Officer: Rex Thornley
Problem Solving Court Treatment Program
605 N. Capital Ave.
Idaho Falls, ID 83402
208-705-5071

You will not be penalized or otherwise retaliated against for filing a complaint**.** If you have questions as to how to file a complaint please contact us at the above address.

Our responsibilities:

This office is required to:

- Maintain the privacy of your protected health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your protected health information; and,
- Abide by the terms of this Notice while it is in effect.

This office reserves the right to change the terms of this Notice at any time and to make a new Notice with provisions effective for all protected health information that we maintain. In the event that changes are made, this office will notify you of a revised Notice by mail at the current address provided on your medical file, or provide you with a notice during your next office visit at the current address provided on your medical file.

To receive additional information:

For further explanation of this Notice you may contact the Problem Solving Court Treatment Program Privacy Officer at the above address and phone number.

This notice will be posted where registration occurs at each counseling office location. You have a right to receive a copy of this notice, and all individuals receiving care will be given a hard copy.

Problem Solving Court Tracking Log

☐ **Accepted** ☐ **Denied**

Name:_____S.S.#_____-____-_____Date:_____ *You are not eligible for admission into a problem solving court if you have not been convicted or plead guilty and sentenced for your crime(s). The following information must be completed prior to submitting the application. Failure to complete all of the information will delay the process of your application.*

Case Number	**Date of Birth**	**Age**	**Highest Grade Completed**
Address:_____ **City:_____** **State:_____Zip:_____** **Phone #_____/_____** **Home Cell**		**Current Location:** *(circle one)* **Bonneville Jail** **Bingham Jail Madison Jail** **Jefferson Jail** **Fremont Jail Other Jail:_____** **Personal Residence**	
Judge:		**Defense Attorney**	
Probation Officer:		**Prosecuting Attorney**	
Crimes:	**Sex Offense Y/N Felony Violent Crime Y/N**		**Child Protection Case: Yes /**
Remaining Jail Time left on your sentence: (circle one) **0-3 months / 3-6 months / 6-12 months / more than 12 months**		**Probation Time:** (years and months left on probation)	
Next Court Date:	**Reason: (circle one) Trial / Sentencing / Rule 35 / Other:_____**		

For Office Use Only

LSI Score: **Date of LSI:**	**Date Received:_____Referred:_____** **M.H. Fel. D.C. Misd. D.C. Wood Family** **Bonneville Bingham Upper Valley Lemhi Butte**	**Applicant Accepted Date:_____** **Court:_____** **County:_____**

Reason(s) for Rejection / Recommendation(s)

_____

_____

Additional Notes

_____

_____

_____

_____

_____

7th JUDICIAL DISTRICT PROBLEM SOLVING COURT APPLICATION

___Felony Drug Court ___Misdemeanor Drug Court ___Mental Health Court ___Wood Pilot Project ___Family Court

IN THE DISTRICT C OURT OF THE SEVENTH JUDICIAL DISTRICT OF THE

STATE OF IDAHO, IN AND FOR THE COUNTY OF _____

STATE OF IDAHO, Plaintiff, -vs.- _____, Full Legal Name (Print Clearly) Defendant.	)	Case No. CR- APPLICATION TO PARTICIPATE IN A PROBLEM SOLVING COURT

Do not leave any section blank. If it Does Not Apply to you then write D/N/A in the margin or on the line.

I hereby apply for admission into a Seventh Judicial District Problem Solving Court. I acknowledge that, as part of the application process:

a. I entered (or will enter) a plea of guilty or was (or will be) convicted of the crime of _____, on the ___ day of _____, 200__; in the County of _____.

b. I am scheduled to be sentenced, or have been sentenced on the ____ day of _____, 200____.

c. My next court appearance is on ___/___/___ with Judge_____.

d. List any unresolved warrants, pending charges, and probation violations.

_____

_____

e. List any prior felony crimes of violence.

_____

f. List any prior sex offenses. _____ (Per Idaho Code, sex offenses and felony crimes of violence are excluded from participating in Drug Court. On a case by case basis, they may be allowed to participate in the Wood Project and Mental Health Court).

g. I have had prior substance use and/or mental health disorder treatment. Please list place(s) and date(s) of treatment:
_____

_____

_____

h. I **do / do not** have a current child protection case with Idaho Department of Health and Welfare.

i. I will be required to complete a substance use and/or mental health disorder screening.

j. My prior criminal record, if any, will be reviewed to determine whether I am eligible to participate in a problem solving court.

k. I will be required to complete a Level of Service Inventory-Revised (LSI-R) evaluation.

l. My application, prior record, the results of the LSI-R, and the results of the substance use and or mental health disorder screening / assessment will be reviewed by a problem solving court screening team. Admission into a problem solving court will be at the sole discretion of the specific problem solving court team.

m. I may/will be required to receive a literacy and or education evaluation. Certain problem solving courts will require a minimum level of literacy and education.

IF ACCEPTED INTO A PROBLEM SOLVING COURT, I AGREE TO COMPLY WITH THE FOLLOWING CONDITIONS OF ADMISSION:

1. I will comply with all requirements contained in the participant handbook of the problem solving court of which I am accepted.

2. I will sign a probation agreement with the appropriate probation department, and fully comply with all requirements of probation.

3. I will authorize release of all treatment information to the problem solving court team which may include, but not be limited to, my attorney, the prosecuting attorney, the judge, treatment representatives, a representative of probation and parole and other community partners. This information may be used by the team to determine my level of participation and compliance with the problem solving court or to modify my release conditions and/or to decide to terminate my participation in the program. The information may also be used to modify or terminate probation. The information will not be used by the prosecuting attorney for the prosecution of any new crime.

4. I will appear in court for all scheduled hearings.

5. I understand that my probation may need to be extended in order to complete the program.

I understand that any failure on my part to comply with problem solving court requirements may result in modification or revocation of my probation, including the imposition of sentence.

DATED this _____day of _____, 200___.

_____

Defendant's Signature

CERTIFICATE OF SERVICE

I hereby certify that on this _____ day of _____, 200____, I did send a true and correct copy of the foregoing document upon the parties listed below by mailing, with the correct postage thereon; by causing the same to be placed in the respective courthouse mailbox; or by causing the same to be hand-delivered.

Prosecuting Attorney

Probation and Parole

By_____

Attorney for Defendant

Background Probation Information

Name: _____ Social Security Number:_____
(Print) Contact Telephone #: _____

Please provide the following information:

List of friends and acquaintances: _____ _____ _____

_____ _____ _____

Race:

- ☐ White
- ☐ Black
- ☐ Native American
- ☐ Asian
- ☐ Other _____

Ethnicity:

- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic
- ☐ Non-hispanic

Education:

- ☐ 4 year college
- ☐ 2 year college
- ☐ Some college
- ☐ Vocational
- ☐ GED
- ☐ Grade 12
- ☐ Grade 11
- ☐ Grade 10
- ☐ Highest grade completed: _____

Type of School:

- ☐ Traditional
- ☐ Alternative/Vocational
- ☐ Home
- ☐ College

Marital Status:_____

Children

Last First Middle

Name: _____ _____ _____

Age _____ In custody of defendant ☐ Yes ☐ No

Affected by drugs at birth ☐ Yes ☐ No Paid past due?

Child Support: *Circle One* Paid

Child Support $_____.00 ☐ week ☐ month ☐ year ☐ unknown

Last First Middle

Name: _____ _____ _____

Age _____

In custody of defendant ☐ Yes ☐ No Child Support : *Circle one*:

Affected by drugs at birth ☐ Yes ☐ No Paid Received past due?

Child Support $_____.00 ☐ week ☐ month ☐ year ☐ unknown

Last First Middle

Name: _____ _____ _____

Age _____

In custody of defendant ☐ Yes ☐ No Child Support : *Circle one*:

Affected by drugs at birth ☐ Yes ☐ No Paid Received past due?

Child Support $_____.00 ☐ week ☐ month ☐ year ☐ unknown

Charges

Case #	Charge	Primary Charge
		☐ Yes ☐ No

Court Ordered Conditions	☐
Community Service	☐
Court Costs	☐
Restitution	☐
Program Fees	☐
Court Fees	☐
Drug Treatment	☐

Criminal History

First Arrest Date: _____ Number of Arrests:_____

Prior Record	☐ Yes	☐ No	☐ Unknown	
Felony Arrest	☐ Yes	☐ No	☐ Unknown	How many _____
Felony Conviction	☐ Yes	☐ No	☐ Unknown	How many _____
Misdemeanor arrest	☐ Yes	☐ No	☐ Unknown	How many _____
Misdemeanor conviction	☐ Yes	☐ No	☐ Unknown	How many _____
Juvenile arrest	☐ Yes	☐ No	☐ Unknown	How many _____
Juvenile conviction	☐ Yes	☐ No	☐ Unknown	How many _____
Drug arrest	☐ Yes	☐ No	☐ Unknown	How many _____
Gang membership	☐ Yes	☐ No	☐ Unknown	

Drug Use History

Order of preference

Substance	_____	Last used	_____
Route of administration	_____	Age at first use	_____
Frequency of use	_____	Cost per day	_____
Substance	_____	Last used	_____
Route of administration	_____	Age at first use	_____
Frequency of use	_____	Cost per day	_____
Substance	_____	Last used	_____
Route of administration	_____	Age at first use	_____
Frequency of use	_____	Cost per day	_____
Substance	_____	Last used	_____
Route of administration	_____	Age at first use	_____

Assessment

Family members with chemical dependency problem:	☐ Yes	☐ No	☐ Unknown
Previous drug/alcohol treatment:	☐ Yes	☐ No	☐ Unknown
Diagnosed with mental illness and substance abuse:	☐ Yes	☐ No	☐ Unknown

Medical

Medical condition: _____

_____

Prescription drugs

Name	Dose	Prescribing physician

Blood-borne diseases

- ☐ Yes ☐ No ☐ Unknown
- ☐ Pregnant at start of program
- ☐ Became pregnant during program
- ☐ Physical abuse
- ☐ Sexual abuse

History & Needs

Prior drug/alcohol treatment

Location: _____

Referral date: _____

Current treatment needs:

- ☐ Alcohol abuse
- ☐ Housing
- ☐ Mental health
- ☐ Parenting skills
- ☐ Life skills
- ☐ Drug abuse
- ☐ Family
- ☐ Physical health
- ☐ Anger management
- ☐ Criminal attitudes
- ☐ Employment
- ☐ Education
- ☐ ADHD
- ☐ History of trauma
- ☐ Other

Comments: _____

Treatment: (drug/alcohol/anger management/domestic violence)

Please list all treatment received, including current and past.

Name of Facility	Type of Treatment	Year Treatment Began/Ended	Length of Attendance

MULTI-PARTY/AGENCY AUTHORIZATION FOR RELEASE OF INFORMATION FOR 7TH JUDICIAL DISTRICT PROBLEM SOLVING COURTS

Legal Last Name	First Name	MI	Date of Birth
Other Names Used		**Case ID#**	

I, _____ voluntarily authorize and specifically request the presiding judge, the prosecuting attorney/deputy attorney, public defender/other defense counsel, and any employee or agent of the Idaho Department of corrections, Problem Solving Court Coordinators and Problem Solving Court Teams, County Probation Staff, the Idaho Department of Health and Welfare (IDHW), IDHW Child Supportive Services, law enforcement agencies, jail detention staff or other educational, vocational, medical or health care providers or agencies to release, use, disclose, receive, communicate to one another, or mutually exchange the following information or records about me:

All of my health care information, medical records, and laboratory/diagnostic tests, from all sources and any other information.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information 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_____

(Initial that you are aware the above areas may be released to the mentioned parties above. Initial all items.)

I have read this information or had this information read to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will. I understand that this information will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior, to submit billings for services, to audit, evaluate, or conduct legitimate research about drug treatment services and effectiveness, 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, the presiding judge, the prosecuting attorney/deputy attorney, public defender/other defense counsel, and any employee or agent of the Idaho Department of corrections, Problem Solving Court Coordinators and Problem Solving Court Teams, County Probation Staff, the Idaho Department of Health and Welfare, law enforcement agencies, jail detention staff or other educational, vocational, medical or health care providers or agencies

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 (HIPPA), 45 CFR Parts 160 &164 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I can revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it and with the understanding that such revocation will end my participation in treatment, which may result in the imposition of criminal sanctions. Although HIPPA 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 final disposition of the case that mandated me 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 the original.

Full Legal Signature of Client or Authorized Personal Representative		Relationship to Client	Date
Full Legal Signature of Parent or Legal Guardian—Required if Client is under 16 years of age, but only after signed by Client.		**Relationship to Client**	**Date**
Name of Staff Person(PRINT)	**Initializing Agency Name/Location Wood Pilot Project**		**Date**

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records which may be protected by federal confidentiality rules (42 CFR Part 2). If the information is so protected, the federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

*PLEASE ENSURE STATEMENTS ON REVERSE HAVE BEEN READ AND INITIALED PRIOR TO SIGNATURE.

MULTI-PARTY/AGENCY AUTHORIZATION FOR RELEASE OF INFORMATION FOR 7TH JUDICIAL DISTRICT PROBLEM SOLVING COURTS

Compliance and Assurance Questionnaire

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

1. I have a clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns. _____

2. I understand that signing this release of information is voluntary and not required._____

3. I was given this release of information prior to beginning treatment services._____

4. I have signed this agreement without fear, intimidation, and/or coercion._____

5. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to the referring agency._____

6. I have been given a summary of the confidentiality laws._____

7. I understand any information regarding ongoing criminal activity on my part is not protected and can be reported._____

8. For criminal justice clients, the termination of this release of information will occur at the time of my completion of court ordered probation and or parole period._____

9. If I am unable to read or comprehend this document, the release of information was read and explained in a manner in which I understood._____

10. I was provided a copy of the release of information after signing._____

*PLEASE ENSURE STATEMENTS ON REVERSE HAVE BEEN READ AND INITIALED PRIOR TO SIGNATURE.