SALT LAKE CITY POLICE DEPARTMENT
COMMUNITY CONNECTION CENTER

INFORMED CONSENT RELEASE FORM

Client Name:	Birthdate:	
Address:	Phone #:	
City:	State:	Zip:

I hereby authorize **Salt Lake City Police Department Community Connection Center employees** to disclose to and/or obtain information from the following organizations: (Client should initial by each agency they agree to allow disclosure with)

_____ Department of Workforce Services	_____ Church of Jesus Christ of Latter Day Saints	_____ ARS
_____ Salt Lake City Justice Court	_____ The Road Home	_____ Clinical Consultants
_____ SLC Prosecutor's Office	_____ Crossroads Urban Center	_____ Cornerstone Counseling
_____ Salt Lake County Sheriff's Office	_____ Catholic Community Services	_____ First Step House
_____ City of Salt Lake	_____ Volunteers of America	_____ House of Hope
_____ Adult Probation & Parole	_____ The Home Inn	_____ Odyssey House of Utah
_____ LDA's Office	_____ University of Utah Health Care	_____ Utah Food Bank
_____ Utah Department of Corrections	_____ Optum	_____ Criminal Justice Advisory Council
_____ District Attorney's office	_____ IHC Health Care	_____ Other: _____
_____ Veteran's Administration	_____ Valley Behavioral Health	_____ Other: _____
_____ Family Counseling Center	_____ Salt Lake County Behavioral Health	_____ Other: _____
_____ United Way	_____ The Fourth Street Clinic	

DESCRIPTION OF INFORMATION FOR RELEASE (Patient/Client should initial by the record option below to allow disclosure.)

_____ All records - including medical records (physical health, labs, & mental health), substance abuse, financial records, police reports, legal records, employment.

_____ Other: _____

_____ All records with the exception of: _____

PURPOSE

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services.

REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Lana Dalton, LCSW at 475 South 300 East, P.O. Box 145497, Salt Lake City, Utah 84114. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION

Unless revoked, this authorization expires 365 days after date of signature.

CONDITIONS

I further understand that the Salt Lake City Police Department Community Connection Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may result in the personnel of the Community Connection Center not being able to assist me to the fullest capacity, as the Connection Center's purpose is to connect individuals to the most appropriate agency to fit their needs.

FORM OF DISCLOSURE

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

RE-DISCLOSURE

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. If this is for a minor in a Substance Abuse Treatment program, both minor and legal parent/ guardian must sign the form. A "Foster Parent" is not the legal guardian and not authorized to sign the form.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE TERMS OF THIS FORM.

Signature of Patient/Client	Date
Signature of Parent, Guardian or Personal Representative	Date
Relationship to client:_____	_____Check here if patient/client refuses to sign authorization

Signature of Staff Witness	Date