Community Partnership of Southern Arizona
Regional Behavioral Health Authority

CPSA PM FORM 4.4.5
Authorization For Use or Disclosure of Confidential Information
Criminal Justice System Referral

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call CPSA at **(800) 771-9889, option 2** or **(520) 318-6946** and someone will help you. This form is available in other languages and formats if you need it.
Si usted tiene problemas leyendo ésta carta por que las letras son muy pequeñas o las palabras son difíciles de leer, por favor llame a nuestras oficinas al **(800) 771-9889 opción 2** o al **(520) 318-6946** y alguien le ayudará. Esta carta está disponible en otros idiomas y formatos si es que lo necesita.

I, _____, aka _____, (
(Name of defendant/member) *(Other name used)*
hereby authorize communication between: _____, behavioral health crisis providers,
(member's comprehensive service provider)
inpatient facilities that provide care to me, and the following entities:

- ☐ CPSA Criminal Justice Team
- ☐ Member's Attorney: _____
- ☐ Pima County Adult Detention Complex
- ☐ Conmed (for purposes of continuity of care in discharge/release planning)
- ☐ Pre-trial services
- ☐ Probation
- ☐ Court (indicate which) ☐ Superior Court ☐ Justice Court ☐ Tucson City Court ☐ Other: _____
- ☐ Mental Health Court/Diversion
- ☐ Parole agency or officer:
- ☐ Other (specify): _____

The purpose of and need for the disclosure is to inform the criminal justice agency (agencies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is as follows:

- ☐ Attendance/lack of attendance at treatment sessions
- ☐ Cooperation with treatment program
- ☐ Diagnosis
- ☐ ISP
- ☐ Other (specify): _____
- ☐ Prognosis
- ☐ Program
- ☐ Title 36/COT ☐ Pending ☐ History
- ☐ Discharge/Release Planning

The above named treating agency (agencies) may release the information only as it pertains to:

☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS

I understand this authorization 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 parole, or other proceedings associated with TR#CR# _____
- ☐ Other: _____
  (specify other time, event, condition when authorization can be revoked or expires)

AHCCCS ID: _____ CIS ID: _____ Date of Birth: __/__/____

Community Partnership of Southern Arizona, Inc.
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(800) 959-1063
cpsaArizona.org

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I understand a revocation of this authorization must be made in writing.

I understand that my alcohol and/or treatment records and behavioral health treatment records are protected under the 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 (HIPAA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. HIV/AIDS information may not be re-disclosed without my written authorization. A.R.S. 36-664(K). Information that is not subject to 42 C.F.R. Part 2 may be subject to re-disclosure.

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any confidential information disclosed under this authorization unless the information is contraindicated. A.R.S. §12-2293(A)

Date: __/ /_____ Time: ____:____ ☐ AM ☐ PM

_____

Signature (member/representative/guardian)

If signed by someone other than the member, state your relationship to the member: _____

AHCCCS ID: _____ CIS ID: _____ Date of Birth: __/ /_____

A copy or facsimile of the Authorization is as valid as the original for purpose of disclosure of confidential information.