



PM FORM 4.4.5
AUTHORIZATION FOR USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, aka _____
(NAME OF DEFENDANT/MEMBER)

hereby authorize communication between:

_____ and
(ALCOHOL/DRUG/BEHAVIORAL HEALTH TREATMENT PROGRAM)

Member's Attorney _____
(NAME OF ATTORNEY)

Pima County Adult Detention Center aka PCADC _____
(NAME OF AGENCY OR STAFF/OFFICER)

Pre-trial Services _____
(NAME OF PRE-TRIAL SERVICE AGENCY OR OFFICER)

Probation _____
(NAME OF PROBATION AGENCY OR OFFICER)

Court Superior Court Justice Court Tucson City Court Other _____

Parole Agency or Officer _____
(NAME OF PAROLE AGENCY OF OFFICER)

Other _____

The purpose of and need for the disclosure is to inform the criminal justice agency (ies) 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:
Prognosis
Program
Title 36/COT

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

- Mental Health
Substance Abuse
HIV/AIDS

I understand that 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 proceeding associated with TR#CR#
(SPECIFY OTHER TIME, EVENT, CONDITION WHEN AUTHORIZATION CAN BE REVOKED OR EXPIRES)

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 Act of 1996 ("HIPPA"), 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 redisclosed 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 redisclosure.

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: _____

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

Community Partnership of Southern Arizona, Inc.
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