Authorization for Use or Disclosure of Protected Health Information
Criminal Justice System Referral

arizona complete health
Complete Care Plan

Member's Name:	**Date of Birth:** _____ / _____ / _____
AHCCCS ID:	**CIS ID:**

I authorize communication between _____ (insert Member's Intake and Coordination of Care Agency), behavioral health crisis providers, inpatient facilities that provide care to me, Arizona Complete Health-Complete Care Plan's Criminal Justice team, and the entities specified below. In accordance with Arizona state law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 CFR 2.35, I understand the following:

1. **Voluntary Authorization**. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
2. **Redisclosure**. Information disclosed to a third party under this authorization may no longer be protected by state or federal law and might be redisclosed by the recipient, ***with the following exceptions***: If I authorize the release of information related to alcohol/drug abuse, communicable diseases (including HIV/AIDS), genetic testing (and information derived therefrom), or medical records or payment records, the recipient is prohibited from redisclosing the information without my authorization, unless permitted to do so under federal or state law. *See* 42 CFR Part 2, A.R.S. § 36-664(G), A.R.S § 12-2802(F), and A.R.S. § 12-2294(E).
3. **Specific Authorizations**. Disclosure of information relating to alcohol/drug abuse, mental health treatment (except psychotherapy notes), communicable diseases (including HIV/AIDS), and genetic testing (and information derived therefrom) require specific authorization. ***By placing my initials on the appropriate line(s) in the Specific Authorizations below,*** I specifically authorize the release of such information to the person(s) indicated below.

I authorize the following participants in the Criminal Justice System to receive information:

Courts (*specify which county or city court*):

☐ _____ County Superior Court ☐ _____ City Court ☐ Justice Court
☐ Mental Health Court/Diversion

Criminal Justice Entities (*select all that apply*)

☐ Detention Treatment Provider ☐ Adult Detention ☐ Pretrial Services ☐ Probation ☐ Parole Agency
☐ Law Enforcement ☐ Fire Department ☐ **Member's Attorney** (*specify name*) _____

Other (*specify*):_____

Purpose/Scope. The purpose of and need for the disclosure is to inform the persons and/or entities listed above of my attendance and progress in treatment. I authorize the following information to be disclosed:

☐ Attendance (or lack thereof) at treatment sessions ☐ Cooperation with treatment program ☐ Prognosis
☐ Diagnosis ☐ Service Plan ☐ Discharge and release planning ☐ Title 36/COT (specify): ☐ Pending ☐ History
☐ Other (specify) _____

Specific Authorizations (*Release of any of the following types of information* ***requires your initials below***):

_____ Alcohol/Drug Abuse Records
_____ Communicable Disease Info (including HIV/AIDS)
_____ Genetic Testing and Related Information
_____ Mental Health Records (except psychotherapy notes)
NOTE: Psychotherapy notes require a separate authorization form.

Effective Period. This authorization will remain in effect and cannot be revoked by me until (*select one*):

☐ 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# (*insert #*) _____

OR

☐ Effective Date or Event (*specify*): _____

_____ _____ / _____ / _____
Signature (Member or Authorized Representative*). Date

**If signed by someone other than Member, please specify relationship/authority for signing.*