

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

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, Cenpatico Integrated Care'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:	
<ol> <li>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.</li> <li>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).</li> <li>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.</li> </ol>	
Lauthorize 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) ☐ Pending ☐ History ☐ Other (specify) ☐ Pending ☐ History ☐ Communications (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 Hea	alth Records (except psychotherapy notes) 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 #)  ☐ Effective Date or Event (specify):	
Signature (Member or Authorized Representative*).  *If signed by someone other than Member, please specify relationship/authority	Date  for signing.

Effective Date: 10/01/2015