MULTI-PARTY/AGENCY
AUTHORIZATION FOR RELEASE OF INFORMATION

Legal Last Name	First Name	MI	Date of Birth
Other Names Used			Case ID#

I, _____ voluntarily authorize and specifically request the presiding judge, the prosecuting attorney/deputy attorney, public defender/other defense counsel, and any employee or agent of the Idaho Department of Corrections, any employee or agent of Idaho County Court Services, the Idaho Department of Health and Welfare, law enforcement or other educational, vocational, medical or health care providers or agencies to release, use, disclose, receive, communicate to one another, or mutually exchange the following information or records about me:

All of my health care information, mental health, medical records, laboratory/diagnostic tests, from all sources and any other information to include:
_____

By placing my initials in the spaces below, I specifically understand that the following highly confidential information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization:

HIV/AIDS ____ Mental Health____ Alcohol/Drug ____ Genetic____ STD____ TB____

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior, to submit billings for services, to audit, evaluate, or conduct legitimate research about drug treatment services and effectiveness, and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between, the presiding judge, the prosecuting attorney/deputy attorney, public defender/other defense counsel, and any employee or agent of the Idaho Department of Corrections, any employee or agent of Idaho County Court Services, the Idaho Department of Health and Welfare, law enforcement agencies or other educational, vocational, medical or health care providers or agencies.

I understand that this information may include material protected under 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 CFR Parts 160 & 164 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I can revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it and with the understanding that such revocation will end my participation in treatment, which may result in the imposition of criminal sanctions. Although HIPAA requires that consents be revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective final disposition of the case that mandated me into treatment. I also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

Full Legal Signature of Client or Authorized Personal Representative	Relationship to Client	Date
Name of Staff Person (print)	Agency Name/Location	Date

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records which may be protected by federal confidentiality rules (42 CFR Part 2). If the information is so protected, the federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.