Family Treatment Court
CONSENT FOR THE RELEASE AND EXCHANGE OF INFORMATION

Consumer Name: _____ Consumer #: _____ DOB: _____

Between: Walworth County Family Treatment Court, including all partner agencies within the team, FivePoint Solutions ACCM, the UW-System, the Wisconsin Department of Justice (DOJ), Division of Law Enforcement Services, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Purpose of the disclosure: The information collected will be used to support program monitoring, evaluation, and statistical analysis.

Information requesting to be released/disclosed/exchanged:

X Criminal/legal background (including adult and juvenile arrests, probation/parole and extended supervision compliance/violation, and assessment scores, charges, convictions, etc.)	X Mental/behavioral health treatment/ history
X Dates (date of birth, date of death, date of treatment and other services, etc.)	X Personally identifiable information (name, social security number, state identification number, etc.)
X Drug screen/test results (including oral swab, breathalyzer, Soberlink, biomarker-urine and hair drug screens, drug screening laboratory confirmation, frequency of attendance of drug screening, and concerns related to sample tampering, etc.)	X Program involvement/progress/discharge
X Education information	X Substance use assessment/diagnosis
X Employment information	X Substance use treatment/history
X Medical information	X Other:_____
X Medications (prescribed)	X Other:_____
X Mental/behavioral health evaluation/ diagnosis	X Other:_____

Disclosure of this confidential information may be made only as necessary for, and pertinent to, my participation in this program. I understand that my alcohol and/or drug treatment records and mental health records are protected under both Wisconsin state statutes and the federal regulations governing Confidentiality 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. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Recipients of the information may re-disclose such information only in connection with their official duties. I understand that I may revoke this consent, verbally or in writing, at any time except to the extent that action has been taken in reliance on it.

This consent is effective on the date signed below and ends 12 months after the date of my discharge from the program. Please note: It is required that follow-up, face-to-face interviews take place at six (6) and twelve (12) months from FTC intake/baseline assessment and upon discharge or termination from the program.

In signing this form, I am granting permission for these agencies to release, disclose, and exchange information outlined above that will be collected during the course of my participation in the program. To the extent allowed by law, information obtained during my participation in the program may continue to be accessed and disclosed for purposes of program monitoring, evaluation, and statistical analysis after

expiration of this consent. No information produced as part of evaluating the program will be identifiable to me.

I understand that I am under no obligation to sign this form and that the organizations listed above whom I am authorizing to use and/or disclose my information may not condition my treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this form. However, participation in the program is conditioned upon signing the consent form. I understand I will no longer be eligible for the program if I either do not sign the consent or revoke the consent.

I understand I have the right to inspect or copy the health information I have authorized to be disclosed by this consent form. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under the Wisconsin Department of Health Services Administrative Code (DHS 92.05 and 92.06).

I understand that I will be provided a copy of the signed form, if I request one.

I understand the information that may be disclosed or exchanged may be only used by the above agencies for authorized governmental activities associated with my participation in the program. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.

I hereby authorize the disclosure and exchange of the information described above.

Consumer Signature: _____

Consumer Name (Please print): _____

Date Signed: _____

Witness Signature: _____

Witness Name and Title (Please print): _____

Date Signed: _____

Acknowledgement of Federal Funding:
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