CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____ authorize:
(Printed name of defendant)

Initial all that apply:

Name or general designation of program making disclosure: _____

☐ NC Department of Community Corrections (Officer supervising my case): _____
☑ NC Division of Motor Vehicles
☑ NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services
☐ _____ ☐ _____
(Name of the appropriate court) (Name of the prosecuting District Attorney)
☐ _____ ☐ _____
(Name of the Criminal Defense Attorney) (- Other -)

to communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

☑ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

☑ referrals, aftercare, treatment completion and/or discharge date

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug 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 and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

[*Specify the date, event or condition upon which this consent expires. This could be one of the following*:]

☐ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

☑ 10 years
(Specify other time when consent can be revoked and/or expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form: _____ Date: _____
(Signature of Patient)

Signature of person signing form if not the patient: _____ Date: _____
(Signature)

Describe authority to sign on behalf of patient: _____