Consent for Release of Confidential Information

I, _____, _____, _____, _____,
NAME OF PARTICIPANT CASE NUMBER DATE OF BIRTH SOCIAL SECURITY NUMBER

Authorize:_____

To release to: Shelby County Veterans Court Team
(See below for team members)

the following information:

Weekly Treatment Reports _X__	Treatment Plan Modifications _X__	Admit and Discharge dates _X__
Treatment Plan/Update __X__	Case Management Plan Updates __X__	Medications __X__
Physical Examination __X__	Release/Discharge Summary _X__	Mental Health Exam __X__

Other – List specific document(s) or information: **Mental Health Diagnosis, Psychiatric History, Psychiatric Evaluation/Report, Medications History, History of Hospitalizations for Psychiatric Treatment, Dates of Treatment**

Information is being released for the following purpose: **Application and Admission to Shelby County Veterans Court**

Date, event or condition when consent expires: **Denial, Graduation or Termination from Shelby County Veterans Court**

In the event no date, event, or condition is specified for expiration, this consent expires ninety (90) days from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I or my legally authorized representative may revoke this consent in writing at any time unless action has already been taken based upon it. This consent may be revoked by submitting a written revocation to the Health Information Department. I freely and voluntarily give this consent.

I understand that the records requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records; the Health Insurance Portability and Accountability Act (HIPAA) of 1996; 45 C.F.R. Parts 160 and 164; and state confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by regulations. State and federal regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE, WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS AQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

_____ _____
SIGNATURE OF PARTICIPANT DATE