IN THE IOWA DISTRICT COURT FOR POLK COUNTY

|  |  |
| --- | --- |
| State of Iowa,  Plaintiff,  Vs.  ,  Defendant. | Case No.  SUBSTANCE ABUSE TREATMENT PROGRAM  AUTHORIZATION FOR RELEASE OF INFORMATION |

I hereby authorize and direct all treatment providers, including, but not limited to the following listed substance abuse treatment program(s) and/or facility(s):

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release and disclose to my assigned probation officer the following information:

YES NO

* Any and all information about my Substance Abuse treatment \_\_\_\_ \_\_\_\_
* Any and all information about my Mental Health condition or treatment \_\_\_\_ \_\_\_\_
* Records about the duration of involvement with the program \_\_\_\_ \_\_\_\_
* Records about my attendance at counseling sessions \_\_\_\_ \_\_\_\_
* Records of my evaluations and treatment recommendations \_\_\_\_ \_\_\_\_
* A summary of my treatment participation \_\_\_\_ \_\_\_\_
* My medical history \_\_\_\_ \_\_\_\_
* My social history \_\_\_\_ \_\_\_\_
* My history with alcohol and/or other drugs \_\_\_\_ \_\_\_\_
* My legal history \_\_\_\_ \_\_\_\_
* The results of any and all urinalysis results \_\_\_\_ \_\_\_\_
* The results of any and all psychological/psychiatric testing and evaluation \_\_\_\_ \_\_\_\_
* Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

upon request, or upon any significant violation of the substance abuse treatment program rules. The information set out above can and should be released to my assigned Probation Officer with the Iowa Department of Correctional Services, for re-disclosure to the Iowa District Court, the Associate District Court, the Polk County Attorney’s Office and my attorney. The purpose for the disclosure and re-disclosure of the above information is to allow these parties to coordinate services in the course of my probation and to allow these parties to monitor compliance with the terms of my probation. To the extent these matters are the basis of a probation revocation hearing, these parties are allowed and authorized to document alleged violations of probation in a report of violations and to testify about these matters in open court.

The confidentiality of alcohol and drug abuse patient records maintained by such treatment programs is protected by Federal law and regulations. Generally such programs may not say to a person outside the program that a patient attends the program, or disclose any information identifying the patient as an alcohol or drug abuser unless (1) the patient consents in writing; (2) the disclosure is allowed by court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

I have been informed concerning current federal confidentiality regulations (CFR 42-2 and CFR 45-160 and 164) and I knowingly, voluntarily, and intelligently authorize the release of this information. No threats or promises have been made to get me to sign this consent form. I understand that this information may be released among and between the listed recipients and may be released in open court, but will not be further released to anyone else by the recipients without my written consent.

I may revoke this consent to release of information at any time, except where actions have already been taken on the basis of this release. If treatment is a term of my probation, I understand that revocation of the release may be grounds for a re-evaluation of my probationary terms or status. If I do not revoke it earlier, this document will be null and void on upon any discharge from probation or revocation of probation. A photocopy shall have the same force and effect as this original.

I understand I have the right to inspect any documents that have been disclosed pursuant to this authorization at any time upon request.

I hereby authorize the release of information as set out above for a period of one year from the date written below, although I understand I can revoke this consent at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Defendant’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Defendant’s Name (printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Defendant’s Date of Birth / Social Security Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Witness's Signature & Title) Date

I acknowledge that I have received a copy of this release of information authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Defendant’s Signature Date