CAMDEN COUNTY PROSECUTOR'S OFFICE

Consent for the Release of Confidential Treatment Information
Page 1

I, _____ do hereby give consent and authorize the Camden County Prosecutor's Office and the Treatment Team*, to have reciprocal verbal communication and to exchange written records with:

Any/all organizations to be contacted include those facilities listed on page 2 of this form

*In addition to the Forensic Nurse, the treatment team includes: Superior Court Judge, Assistant Prosecutor and members of the Camden County Prosecutor's Office, Assistant Deputy Public Defender, Private Attorney, Probation Supervisor and Investigation Officer(s), Team Leader, Court Clerk, Camden County Department of Human Services and Mental Health Providers.

		I DO GIVE CONSENT (Initial Line)
1	Addiction Severity Index	_____
2	Bio-Psychosocial Assessment	_____
3	Current Medications	_____
4	Results of Psychiatric Evaluation(s)	_____
5	Discharge Summary	_____
6	HIV Test Results	_____
7	Medical and Physical Examination Results	_____
8	Other Medical Test Results	_____
9	Admission/Intake Summary	_____
10	Program Attendance, session date, type, frequency	_____
11	Results of Psychiatric Evaluations(s)	_____
12	Psychiatric or Psychosocial Progress Reports	_____
13	Summary of Diagnosis	_____
14	Current Symptoms and Treatment Plan	_____
15	Statement of Treatment Prognosis	_____
16	Statement of Treatment Status/Progress	_____
17	Results of drug testing (including and not limited to urine, saliva, breath and perspiration)	_____
18	_____	
19	_____	
20	_____	

The purpose of the disclosure authorized herein is to facilitate my participation in the mental health program. I 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 will remain in force for no more than a period not to exceed one year or my probation term which ever is grater in order to effectuate the purpose for which it was given.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my consent unless otherwise provided for in the regulations.

_____ _____
Date of Signature Defendant's Signature

_____ _____
Date of Witness Signature Witness Signature, Title

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I UNDERSTAND
(Initial Line)

The purpose or need for such disclosure authorized herein is to comply with conditions of the mental health program, assist with assessment and appropriate referral and/or to keep the Camden County Prosecutor's Office and the Treatment Team informed of my status in treatment. _____

I understand that my compliance with Court Order and/or Probation relies upon communication between the treatment team and the treatment provider selected for me. _____

I understand that the Evaluator may contact the following facilities in order to facilitate my placement in the program. _____

Fill in names of resources

Mental Health Providers:

Name: _____
Address: _____
_____
Phone Number: _____

Name: _____
Address: _____
_____
Phone Number: _____

Name: _____
Address: _____
_____
Phone Number: _____

Substance Abuse Providers:

Name: _____
Address: _____
_____
Phone Number: _____

Name: _____
Address: _____
_____
Phone Number: _____

Name: _____
Address: _____
_____
Phone Number: _____