IN THE CIRCUIT/COUNTY COURT OF THE 20TH JUDICIAL CIRCUIT
IN AND FOR CHARLOTTE COUNTY, FLORIDA

GENERAL CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:

I, _____, _____, hereby consent
(Name of client) (Case Number)
to reciprocal Communication between the Charlotte County Treatment Court employees, serving as Treatment Court coordinators and case managers, and those participating in Treatment Court case management conferences and their supervisors, and all Clinicians/Therapists, Medical Doctors, Psychologists/Psychiatrists, drug testing provider, and any other treatment provider, and my attorney of record, to communicate with, share, and disclose to one another all of my substance abuse treatment information including identifying information, mental health, psychiatric, and medical information, diagnoses, urinalysis and other substance testing results, attendance or lack of attendance at treatment sessions and appointments, my cooperation with treatment, progress in treatment, and opinions concerning my prognosis within the specific treatment court to which I have been referred and/or accepted. The purposes of the disclosure are to assist the above in evaluating and managing my substance abuse and mental health recovery.

The information disclosed to the members of the Treatment Court Team shall only be used in connection with my Treatment Court case(s) referral, the Treatment Court proceedings and the prosecution of my Treatment Court case. The information disclosed to the members of the Treatment Court Team shall not be used to generate new criminal cases and shall not be used against me as evidence in a new criminal case.

This consent will remain in effect until there has been a formal and effective termination of my involvement with the Treatment Court Program for the above referenced case.

I understand that any disclosure made between the above named agencies or individuals is bound by 42 CFR 2.35 and 42 USC 290dd-2, which are the Code of Federal Regulations governing confidentiality of substance abuse patient records, and that recipients of this information may re-disclose it only in connection with their official treatment court duties. I have received and/or know where I may request a copy of this signed form.

I also understand that I am waiving any HIPAA Rights.

I acknowledge that I have received a copy of this form, and I am signing this consent voluntarily.

_____ _____
Printed Name (Client) Client Signature Date

_____ _____
Printed Name/Title (Witness) Witness Signature Date