133 West State Street, Sycamore, Illinois
Phone: 815-895-7224 Fax: 815-787-9625

DeKalb County Treatment Courts

AUTHORIZATION FOR RELEASE OF INFORMATION

Participant's Name:		Date of Birth:	
Previous Name:		Social Security #:	

I authorize the DeKalb County Treatment Court Team to:

(Team includes Treatment Court specific Judge, Coordinator, Treatment Court Officer, Treatment Court Counselor, Treatment Court EHM Officers, Treatment Court Public Defender, Treatment Court State's Attorney, Treatment Court Corrections Officers)

☐ OBTAIN ☐ DISCLOSE information in written, verbal and/or electronic form ☐ FROM ☐ TO:

	Name/Agency:			
	Address:			
	Phone Number		Fax	

This disclosure is needed for ☐ probation investigation ☐ treatment planning and assessment ☐ continuity of care ☐ _____ (other) purposes. Information to be disclosed may include:

_x_ Summary of Treatment (including diagnosis, treatment plan, progress notes, services, duration, assessment)
_x_ Summary of Psychiatric Treatment and Evaluation (including diagnosis and medications)
_x_ Psychological Evaluation and Test Results
_x_ Medical Records and Labs (including assessment, treatment, duration, medications, and diagnosis)
_x_ Healthcare information relating to the following conditions or treatment: _____
_x_ Drug Test Results
_x_ Progress Reports (includes probation/case management progress notes, violations, labs, and achievements)
☐ Other (list) _____

Release of the information explained below--if included in records described above—is authorized to be released:

☐ Yes ☐ No

Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. **Mental health** treatment records, developmental disability records, psychological services and social services information. **Results of HIV testing and/or genetic testing**, as defined by the Genetic Information Privacy Act. **Communicable disease and infection** information, as defined by statute and Illinois Department of Public Health

I certify that this request has been made freely, voluntarily, and without coercion. I understand that it is my right to revoke this consent for the release of this information, in writing, at any time. Without my express revocation, I understand that this consent will automatically expire on ____/____/____. I consent to allow release of only the information listed on this consent form. I understand it is my right to contact the provider and request and inspect the information that is to be disclosed. I accept the above terms and authorize disclosure:

Participant Signature:		**Date Signed:**	
Witness Signature:		**Date Signed:**	

Notice to Receiving Agency/Person: Under the provisions of the Illinois Mental and Development Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under the Federal Act of July, 1975, Confidentiality Alcohol and Drug Abuse Patient records, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.