ADMINISTRATIVE OFFICE OF THE COURTS
THIRTEENTH JUDICIAL CIRCUIT
Drug Court Programs Office
801 E. Twiggs Street, Room 608
Tampa, Florida 33602

Drug Court Specialist II **Fax: 813-301-3819**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION-Treatment Providers

I, _____ **DOB** _____
(Client Name)

Authorize the Administrative Office of the Courts, to disclose and exchange with the following individuals within Substance Abuse and Mental Health treatment agencies
****Name of organization to receive information required****

- ☐ Public Defender's Office State
- ☐ Attorney's Office Private
- ☐ Attorney
- ☐ Problem Solving Court Staff
- ☐ Judge Denise Pomponio
- ☐ Tri County Human Services
- ☐ Phoenix House
- ☐ Operation PAR
- ☐ Westcare
- ☐ Centerstone
- ☐ Therapy 4 Change
- ☐ Naphcare (Jail medical records)
- ☐ Medical Records-Jail
- ☐ Salvation Army
- ☐ Amethyst Respite Center
- ☐ Department of Corrections
- ☐ DACCO
- ☐ ACTS
- ☐ Selah Freedom
- ☐ Created
- ☐ Gracepoint
- ☐ Sober Solutions Counseling
- ☐ First Step of Sarasota
- ☐ Other: _____

Purpose for the disclosure: To assist me in completing requirements for the agencies designated above and in successfully completing drug offender probation including requirements of Problem Solving Courts.

To communicate and disclose the following information to another as necessary and appropriate connection with their official duties in my case:

- ☐ All my substance abuse and mental health records
- ☐ Medication Administration Records

Information may be disclosed by the following methods: Mail, Verbal, Faxing, and encrypted email unless otherwise specified.

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. I understand that I have a right to request a copy of this form.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration: Upon Case Closure

Executed this _____ day of _____, 20_____.

Signature of the participant _____

Signature of the Witness _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose