ADMINISTRATIVE OFFICE OF THE COURTS
THIRTEENTH JUDICIAL CIRCUIT

Adult Drug Treatment Court Program Office
801 E. Twiggs Street, Room 608
Tampa, Florida 33602

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

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ **DOB:** _____
(Applicant's Full Name)

hereby authorize the Administrative Office of the Courts to communicate, receive, disclose, and exchange my information with the following individuals, offices, and agencies as necessary and appropriate in connection with my case:

**** PLEASE CHECK EACH BOX AS APPLICABLE ****

- ☐ Public Defender's Office
- ☐ Private Attorney's Office
- ☐ State Attorney's Office
- ☐ Problem-Solving Court Staff
- ☐ Problem-Solving Court Judge
- ☐ Tri County Human Services
- ☐ Phoenix House
- ☐ Operation PAR
- ☐ Westcare
- ☐ Centerstone
- ☐ Riverside Recovery
- ☐ Naphcare (HCJ Medical Records)
- ☐ Veterans Administration (VA Medical Records)
- ☐ Salvation Army
- ☐ Turning Point of Tampa
- ☐ Department of Corrections
- ☐ IBIS - Cove
- ☐ IBIS - Gracepoint
- ☐ ACTS
- ☐ Selah Freedom
- ☐ Sober Solutions Counseling
- ☐ First Step of Sarasota
- ☐ Other: _____

Purpose for the Disclosure: To assist me in completing requirements for the offices, agencies, and treatment providers designated above and successfully completing drug offender probation including requirements of the problem-solving court.

To communicate, receive, disclose, and exchange the following information as necessary and appropriate in connection with my case:

- ☐ All my substance abuse and mental health treatment records
- ☐ All my medication administration records

Information may be disclosed by the following methods: verbal, mail, fax, and encrypted email, unless otherwise specified below:

_____

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 Applicant: _____

Signature of 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.