19th Judicial District
MENTAL HEALTH COURT

2 Millennium Plaza
Clarksville, TN 37040
Phone: (931) 648-5511

Consent for Disclosure of Confidential Information

I, _____, hereby consent to communication between the Mental Health Court Judge, Office of the District Attorney General, Office of the Public Defender, MHC staff, Substance Abuse and/or Mental Healthcare Providers, Montgomery County Sheriff's Office, Montgomery County Criminal Court Clerk, Judicial Representatives, Student Interns, my Probation Officer(s), and the following individuals:
_____

The purpose of and need for this disclosure is to inform the Court and other above-named parties of my eligibility and/or acceptability for the MHC program and my attendance, prognosis, compliance, and progress in accordance with the MHC monitoring criteria.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the MHC, such as discontinuation of all Court and upon my successful completion of the MHC requirements or upon sentencing for violating the terms of the MHC Program.

If applicable, please initial the appropriate blank in the following statements:

1. Alcohol or Drug Treatment Records. I DO _____ I DO NOT _____ authorize the use or disclosure of drug or alcohol abuse treatment records. I understand that these records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse to release this information.

2. HIV status. I DO _____ I DO NOT _____ authorize the release of HIV test results for the purpose set forth above.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs confidentiality of substance abuse patient records, and by Part 46 of Title 45 of the Code of Federal Regulations, which governs the protection of human subjects, and that recipients of this information may redisclose it only in connection with their official duties.

A copy of this authorization shall be considered as effective and valid as the original. I hereby authorize the 19th Judicial District Mental Health Court or any of its staff to use or to disclose, by any acceptable means, including fax or email, my Protected Health Information.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

_____
Printed Name of Staff/Witness

_____ _____
Signature of Staff/Witness Date