Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – CRIMINAL JUSTICE

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Client ID #

Date of Birth	Social Security No.	Home Phone	Work Phone	Extension

Street Address	City	State	Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

SUD Treatment Provider	Phone Number	Extension

Street Address	City	State	Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY <u>EACH PERSON NAMED BELOW</u>:

Probation Officer(s)	Phone Number	Extension

Street Address	City	State	Zip Code

Attorney(s)/Public Defender(s)	Phone Number	Extension

Street Address	City	State	Zip Code

Drug Court Case Manager(s) & Analyst(s)	Phone Number	Extension

Street Address	City	State	Zip Code

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EXPIRATION: This Authorization expires: (☐) conclusion of pending criminal or juvenile justice court proceeding in Alameda County
(☐) final disposition of conditional release
(☐) other (if shorter duration than either of above): _____

Disclosure Purpose	**Amount and Kind**
• Assessment & suitability for the collaborative courts, including Drug Court • Pending criminal or juvenile justice proceedings • Court-required reporting and monitoring, including for conditional release or juvenile justice program • Medication and medication compliance; drug testing results • Attendance, participation, and compliance with treatment program, and ongoing coordination of care for collaborative court purposes • Prognosis and progress with treatment • Operations activities for the collaborative courts • Research, evaluation, audit	• Limited to that information which is necessary to carry out the Disclosure Purpose within the criminal justice system • I permit lawful holders to re-disclose my protected SUD information subject to this authorization and 42 CFR part 2 • Other: _____

_____	_____	_____
Signature of Patient	Print/Type Name	Date

_____	_____	(☐) Parent	_____
Signature of Parent or Guardian	Print/Type Name	(☐) Guardian	Date

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION:
42 CFR part 2 prohibits unauthorized disclosure of these records.

An individual within the criminal justice system who receives patient information under 42 CFR part 2, sec. 2.35 may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

This form was originally completed by client with
the following BHCS SUD provider-contractor: _____
[PRINT NAME of BHCS SUD Provider-Contractor]