Maricopa County

Maricopa County Sheriff's Office, Correctional Health Services, Adult Probation, Human Services Department, Community Providers

Authorization for the Release of Information

Client Name: _____ DOB: _____ SSN: _____

Booking#:_____Date of initial booking: _____ Release date (if known): _____

I, _____,as the (client or person authorized to sign on behalf of the client), hereby authorize recognized entities of the Maricopa County Smart Justice Council and others specifically identified below to disclose and share written and oral information for the purpose of coordination of care while in custody and to support my transition to the community. This form is intended to allow for a multiple agency/entity collaboration to most effectively address and accommodate identified health, mental health, and/or human service needs I may have.

Please initial next to the specific entities to whom you authorize a release and sharing of information:

_____ Maricopa County Sheriff's Office Inmate Programs staff including program coordinators, counselors, and social workers
_____ Maricopa County Correctional Health Services (CHS)
_____ Maricopa County Adult Probation Department
_____ Human Services Department of Maricopa County
_____ RBHA, behavioral health organization, other community provider, or vender who receives Medicare of Medicaid services (Please specify):_____
_____ Medical Care Providers (PCP) _____Phone Number: _____
_____ Maricopa County Smart Justice Council administratively approved contracted treatment providers /vendors. A provider/vendor is any agency or entity that is contracted to provide treatment or other services in the jail for a fee. *A list of vendors can be made available upon request.*
_____ (Other) family members, community supports, emergency contact, community agencies, community treatment providers (**Include names and contact information**):
_____
_____

Please initial next to the types of information to share and/or release (if applicable):

___Assessment(s)/Testing ___ MCSO Adult Program enrollment/participation ___Diagnosis/es
___Transition/Discharge plans ___ Case management/progress notes ___ Re-Entry Referrals
___Medication list ___Treatment plans and Final Reports
___Other types of information not listed:_____

SPECIFIC AUTHORIZATION FOR RELEASE:

I understand that health information may include HIV-related information and/or relating to diagnosis or treatment of psychiatric abilities and/or substance abuse. By signing within this box, I am specifically authorizing the release of information related to:
_____Mental Health records
_____HIV related information (including AIDS related testing)
_____Substance abuse (including alcohol, prescription medications, both legal/illegal drugs)
The confidentiality of this information is required under Arizona state regulations as well as 42 CFR Part 2. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X_____ _____
(Client Signature, Guardian, or other Person authorized by law to act on behalf of the client) (Date)

1. I hereby request and give my permission for an open exchange of the above identified/specified information to, by, among, or between, any person, entity, agency, or organization indicated/specified in this authorization.
2. I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose of the release of information. I am signing this authorization voluntarily and of my own free will. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
3. I understand I may refuse to sign this authorization and refusal to do so will not be a condition of my treatment.
4. I understand that this authorization can be changed or revoked at any time by submitting a written request to any entity identified herein.
5. I understand that this authorization **will expire one calendar year** from the **signed date** of this form; that a copy of this form can be obtained upon request.

X_____ _____ _____
(Client Signature, Guardian, or other Person authorized by law to act on behalf of the client) (Booking #) (Date)

X_____ _____ _____
(Staff/Witness Signature) (Position/Employee ID #) (Date)

Notice to recipient. *Under A.R.S. § 36-509(A)(18), records may be disclosed to a person or entity as permitted by the federal regulations on alcohol and drug abuse treatment at 42 C.F.R. § 2. If the disclosed information relates to substance abuse treatment, the confidentiality of these records is protected by federal law. Federal regulations, 42 CFR § 2, prohibit further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by the regulations. Under federal law, a general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Regulations restrict any use of information related to substance abuse treatment for the criminal investigation or prosecution of any substance abuse patient.* •••Revised 09/2014•••