CONFIDENTIAL

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO ☐ CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101 ☐ CENTRAL DIVISION, COUNTY COURTHOUSE, 220 W. BROADWAY, SAN DIEGO, CA 92101 ☐ EAST COUNTY DIVISION, 250 E. MAIN ST., EL CAJON, CA 92020 ☐ NORTH COUNTY DIVISION, 325 S. MELROSE DR., VISTA, CA 92081 ☐ SOUTH COUNTY DIVISION, 500 3RD AVE., CHULA VISTA, CA 91910	*FOR COURT USE ONLY*
PEOPLE OF THE STATE OF CALIFORNIA	
DEFENDANT	SUPERIOR COURT CASE NUMBER
CONSENT FOR RELEASE & EXCHANGE OF CONFIDENTIAL HEALTH INFORMATION (HIPAA) – COLLABORATIVE COURT PROGRAMS (CONFIDENTIAL)	OTHER IDENTIFYING NUMBER(S)

I, _____, hereby consent to the release and exchange of confidential health information among the _____ (*collaborative court*) team members, including but not limited to the following: _____(*treatment provider*), San Diego Sheriff's Department, San Diego Public Defender's Office, San Diego District Attorney's Office, San Diego City Attorney's Office, San Diego Superior Court, San Diego Police Department or other local police agency, San Diego Probation Department, and Judicial Council of California. The purpose and need for this release is to assist in evaluating and determining appropriate treatment, progress, and compliance with the collaborative court program.

Information/Records to be Released

- ☒ Mental Health Evaluation
- ☒ Medication Records
- ☒ Psychiatric Assessment
- ☒ Client/Service Plan
- ☒ Physician Orders
- ☒ Diagnosis
- ☒ Billing Records
- ☒ Nursing Notes
- ☒ History & Physical Exam
- ☒ Laboratory Results
- ☒ HIV/AIDS Information/Results
- ☒ Progress Notes
- ☒ Pharmacy Records
- ☒ Psychological Evaluation
- ☒ Alcohol/Drug Treatment Records
- ☐ Other: _____

I understand that the information in my records authorized for release may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). As indicated above, it may also include information about mental health services or treatment for substance abuse.

I understand that my alcohol and drug treatment records are protected by the Federal Regulations governing Substance Abuse Patient Records (42 C.F.R., § 2.1 et seq.) and the Health Insurance Portability and Accountability Act ("HIPAA") (45 C.F.R., §§ 160.101 et seq. and 164.102 et seq.) and cannot be released without my specific written authorization, unless the disclosure is otherwise provided for in the above-referenced regulations. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in the Code of Federal Regulations (45 C.F.R., § 164.524).

I understand that I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing. Revocation will not apply to information that has already been released based on this authorization.

I agree that a photocopy or fax of this authorization for release and exchange of confidential health information will be as effective as the original.

This authorization will go into effect on the date of signing and will remain in effect until the collaborative court program termination, completion, or authorization is revoked.

I request a copy of this authorization. (Initial here for copy): _____ Copy given: ☐ YES ☐ NO

Date: _____ Date of Birth:_____ Social Security Number:_____

_____ _____

Type or print Participant's full name Signature of Participant

Clear This Form