

Authorization for Use & Disclosure of Protected Health Information (PHI) In the Criminal Justice System

I,, hereby consent to comm	unication between
(Print Participant Name - subject of PHI)	
ATTIC Correctional Services, Inc. (ACS) and individual/agency/entity to whom PHI magnuthorize redisclosure between ACS and the parties named here:	y be disclosed and I
(Circuit Court No., Dept. of Corrections, DA's Office, Police Dept., Sheriff's Dept., Attorney, Referring	Agency or Individual)
The purpose of and need for disclosure and re-disclosure is to inform the criminal jurabove of my attendance and progress in treatment. The extent of information to be disc diagnosis/initial screening, treatment plan(s), progress and compliance, treatment prognosis, discharge plan and status, urinalysis and breathalyzer results, and any other information:	losed is my assessment t session, attendance,
Your Rights With Respect To This Authorization	
General Statement of Rights: Federal and state laws protect the confidentiality of my PHI including but not Mental Health –Sec. 51.30, Wis. Stats; & HFS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse –Sec. Wis. Admin. Code; Minnesota Statute 144.335; and 42 CFR Part 2 Final Rule governing confidentiality of patient records and that recipients of this information may redisclose it only in connection with their official Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Right to Receive a Copymave a right to receive a copy of this form after I sign it. Right to Refuse to Sign This Authorization: I am usign this form however, under certain circumstances permitted under applicable law; refusal to sign may re Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by provious withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effect individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/on made prior to receipt of my withdrawal statement. Re-disclosure: If I authorize release of PHI to an individual property of the receive copies of my PHI as permitted by law. I may be charged a reasonable fee for the INITIAL ONLY ONE I understand that this authorization will remain in effect and cannot be There has been a formal and effective termination or revocation of my proba	51.30 Wis. Stats, HFS 92, alcohol and drug abuse al duties. Health Insurance of This Authorization: I under no legal obligation to esult in denial of services. ding a written statement of ctive until the r disclosures of my PHI dual or agency not covered nd/or Copy PHI: I have the less copies.
There has been a formal and effective termination or revocation of my proba conditional release or other proceeding under which I was mandated into tre	
Authorization expires 12 months from the date I sign this authorization.	
Authorization expires after the following action occurs:	
have read or had read to me the contents of this authorization. I have had an opportunity questions. By signing this authorization, I am confirming that it accurately reflects my will be asserted by PHI. A photocopy, fax or electronic image of this authorization shall be as	ishes regarding dis-
Signature of Participant Who is Subject of PHI	Date Signed
Signature of Other Person Legally Authorized to / Title or Relationship To Individual Consent to Disclosure (If Applicable) Who Is Subject of PHI	Date Signed