PARTICIPANT:

DOB: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Case Number(s):

I hereby consent to and authorize written, electronic, and verbal communication of confidential information concerning me and my child(ren) between the Family Healing to Wellness Court Team members (“FHTWC”) for purposes of my participation in the FHTWC program.

The purpose of the form is to enable the FHTWC team to make appropriate decisions regarding my suitability for FHTWC and to better serve me through coordinated service planning and delivery of services. FHTWC team members will share confidential information about me when needed to manage or provide services to me. They may meet and share information regarding me at scheduled pre-court staffings and court hearings. The FHTWC team members may also share written, electronic, and verbal information regarding me before pre-court staffings for the purpose of these staffings and court hearings.

This authorization is valid for past, present, and future services. This authorization expires upon termination from/completion of the FHTWC program, and information is no longer needed to manage or provide services to me or when I revoke this authorization in writing, whichever is sooner. This authorization is automatically revoked if I am not accepted into the program.

The information released at or before pre-court staffings and Court hearings may include the following about my children and me:

* Name
* Attendance/progress in alcohol and drug treatment
* Attendance/progress in mental health treatment
* Attendance/progress in family/parenting interventions/therapies
* Diagnostic information
* Drug and alcohol testing results
* Medical history/exam data/records
* Counseling records
* Psychological/psychiatric history and evaluations
* Work, school, and social reviews and histories
* Plans about services or benefits
* Legal history/involvement and probation/supervised release compliance
* Any information regarding my Child in Need of Protection or Services (CHIPS) case (including compliance/progress with my treatment plan) and human or social services history

*Initial here:*

\_\_\_\_\_\_\_\_\_\_ I understand that the FHTWC team will meet and review my progress before each Court appearance. I will not attend that meeting, but my attorney may attend.

\_\_\_\_\_\_\_\_\_\_ I understand that the FHTWC Case Manager will access treatment attendance, treatment assessment, progress and recommendations, and sobriety monitoring results that may be shared directly with the Court and FHTWC team members. Additionally, the FHTWC Case Manager will collect information/requests from my attorney to share with the Court and team members.

\_\_\_\_\_\_\_\_\_\_ I understand that my alcohol and drug treatment records, mental health diagnosis/treatment records, and health diagnosis/treatment records are protected by federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and may also be protected by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

\_\_\_\_\_\_\_\_\_\_ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it and that, in any event, this authorization expires automatically upon termination from FHTWC or completion of the FHTWC program. If I revoke my consent to these disclosures, I will no longer be able to participate in the FHTWC, and my service providers may change.

\_\_\_\_\_\_\_\_\_\_ To monitor and improve program effectiveness, the Mille Lacs Band FHTWC regularly reviews outcomes and may participate in an evaluation or ongoing research project. This effort may require the above information to be shared with outside evaluators engaged in program evaluation. Any information shared will be non-identifying. The above information may be shared or utilized for evaluation purposes, even after I am no longer in FHTWC. All information will be treated confidentially. Any findings will be summarized and reported as group information and will not be linked to me personally.

Further, by signing this Authorization Form, I agree that I have read and understand the information on this form.

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REVOCATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Participant) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ (date of birth), hereby revoke this Consent for Release of Information within the Mille Lacs Band Family Healing to Wellness Court Team.

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Revocation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_