OREGON SPECIALTY COURT
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

By signing this form, I,_____, or my authorized representative, consent to and authorize **Jackson County Wellness Court** ("Program") and the following entities:

- ☒ Jackson County Circuit Court
- ☒ Jackson County District Attorney's Office
- ☒ Jackson County Community Justice
- ☒ Southern Oregon Public Defenders
- ☒ Medford Police Department
- ☒ Jackson Co. Jail and MedHealth/Medtrust
- ☒ Asante hospitals and clinics
- ☒ Providence hospitals and clinics
- ☒ Oregon State Hospital
- ☒ Beckett Center
- ☒ Crisis Resolution Center
- ☒ Rogue Retreat, OHRA, Hope House
- ☒ Jackson County Mental Health
- ☒ Options for Southern Oregon
- ☒ Columbia Care Services
- ☒ Ontrack Rogue Valley
- ☒ Addictions Recovery Center
- ☒ Veterans Affairs
- ☒ La Clinica Health Centers
- ☒ Rogue Community Health
- ☒ Southern Oregon DBT
- ☒ Oasis Center of the Rogue Valley
- ☒ Paradigm Mental Health & Wellness
- ☒ Developmental Disability Services

- ☐ Legal Guardian or Payee: _____
- ☐ Family or support: _____
- ☐ Other provider: _____
- ☐ Other: _____

to disclose my information and communicate with one another regarding my eligibility and/or acceptability for the Program, to monitor my progress in and compliance with substance abuse and/or mental health treatment services, and to monitor my compliance with Program requirements and directives. This includes sharing with each other my assessment results, diagnostic conclusions, prescribed medications, unprescribed substance use, screening results, referrals to treatment and other services, treatment attendance records, progress in treatment,

compliance with treatment, and compliance with Program requirements and directives. My information may also be disclosed in connection with an audit or evaluation of the performance of the Program and to determine whether the Program is following best practices such as the Oregon Specialty Court Standards.

I understand that my alcohol, drug, and/or mental health treatment records are protected under applicable state and federal laws and regulations including, without limitation, ORS 3.450, the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 C.F.R. Parts. 160 & 164.

I understand that I have no legal right to participate in the Program and that this consent is required to participate in this Program. This consent form will be used to obtain information to assess my compliance and progress toward achieving the Program's objectives. The Program is separate from treatment programs and other services I may receive while in the Program.

If I sign this consent, my information will be disclosed to the people or programs listed on this form. The information disclosed to an entity covered under the HIPAA Privacy Rules may only be redisclosed with my written authorization or under other provisions of the HIPAA Privacy Rules. Information disclosed pursuant to this authorization may no longer be protected by the HIPAA Privacy Rules if it is disclosed to people or programs that are not subject to the HIPAA Privacy Rules. For example, the judge and attorneys who receive the information are not subject to the HIPAA Privacy Rules. However, the other federal regulations that protect my information will continue to apply. If my information is disclosed to a person or entity not covered by the HIPAA Privacy Rules, that person or entity may only redisclose my records with my written authorization or under other provisions of the federal regulations.

Identifying information including treatment status and compliance with Program requirements may be disclosed in the normal course of court proceedings open to the public and recorded in court data information systems available to the public, and I hereby authorize such disclosure. I understand that it is possible that an observer could make the connection between specialty court participation and substance abuse and/or mental health treatment. I understand that information disclosed during court proceedings will no longer be protected by the HIPAA Privacy Rules.

I understand that my treatment records and other treatment related information cannot be used to investigate, initiate, or substantiate criminal charges against me. However, federal laws and regulations do not protect information related to the commission of a crime, or any threat to commit a crime, while on Program premises or against Program personnel. Additionally, federal laws and regulations do not protect information related to suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I understand that I may revoke this consent at any time. If I revoke my consent orally, I agree to confirm my revocation in writing. **I understand that this consent agreement is a condition of the Program and if I revoke my consent I will be terminated from the Program.** Revoking my consent will not affect any information that was previously disclosed.

This consent will expire upon my completion of, or separation from, the Program.

OPTIONAL: ☐ I consent to receiving courtesy text messages from the Program related to my participation in the Program. Cellphone# _____

I understand that standard text and data charges may apply. I understand that I may revoke my consent to receive text messages at any time by notifying the Program's court coordinator or by replying STOP to a text message from the Program. Unless revoked, my consent to receive text messages will remain in place so long as I am a participant in the Program.

I have read and understand the contents of this consent. I fully understand my rights and I am signing this consent voluntarily. I understand that, by signing this consent form, I am authorizing disclosure of my protected health information, as outlined above, to the persons and/or entities listed on this form. I further understand that this consent will be in effect for the duration of time I am in the Program. I am not under the influence of drugs or alcohol.

Printed Name: _____

Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____

Witness Name/ Position: _____

Witness Signature: _____ Date: _____