SCAO Model Document

Documents: Program Visitor Confidentiality Form and Consent to Release Information

Program Type: Problem-Solving Courts

This model document is provided by the State Court Administrative Office (SCAO) as a resource and is for informational purposes only to assist courts with operating a problem-solving court to comply with the problem-solving court statute, and federal and state confidentiality laws. This model document is not intended (and cannot be construed) as legal advice.

Customize the sections that are in bold and highlighted in yellow. Once customized, the court should remove the brackets, bold, and highlighting.

As a model document, it is generic in nature and should be modified to fit your program.

Before developing your confidentiality documents, please review the University of New Hampshire's School of Law/Institute for Health Policy & Practice's "Substance Use Disorder Treatment Confidentiality Boot Camp" guide located at https://chhs.unh.edu/sites/default/files/substance-use-disorder-privacy-part-2-idn-workbook-unh-1017.pdf.

If all participants do not sign the consent to release confidential information prior to the staffing meeting, visitors should not be attending the portion of the staffing meetings where those participants are discussed. Instead visitors should attend the portion of the staff meeting where only participants with signed releases are discussed.

[Name of PSC] Program Visitor Confidentiality Form

I, _____, as a guest of the **[Name of PSC]** Program, recognize my responsibility to maintain the confidentiality of the **[Name of PSC]** Program, and hereby agree that:

1. Any and all information discussed at the [**Name of PSC**] staffing team meeting must remain confidential and shall not be revealed to anyone.

2. If I receive a copy of case reports for a staffing team meeting, I will return all reports in their entirety to a team member at the end of the staffing team meeting.

3. I shall abide by the **[Name of PSC]** program's Memorandum of Understanding (MOU) regarding confidentiality (attached).

4. I understand that alcohol and/or drug treatment records, medical records, and mental health records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 & 164, and MCL 300.1748 of the Michigan Mental Health Code. I shall abide by the confidentiality provisions of the law.

5. By signing this form, I confirm that I have read and agree to the above statements.

_____ _____

Signature of guest Date

_____

Printed name of guest

[Name of PSC program]
Consent for Release of Information
Observation of Staffing Meeting

Participant's Full Name: _____ DOB: _____

I authorize the following parties**:**

1. **[Name of problem solving court],**
2. **[Name of county]** MDOC probation/parole department
3. **[Name of district court]** probation department
4. **[Name of county]** prosecutor's office
5. **[Name of treatment agency]**
6. **[Name of law enforcement agency]**
7. **[Name of law firm/office, or name of attorney]**

To release information to the following parties:

1. Stakeholders of **[name of PSC program observing meeting]**
2. **[Name of agency evaluating program]**[1]

To disclose information discussed at the staffing meeting, held on **[date]**, which may include the following information:

INFORMATION TO BE SHARED

1. Name, address, and other personal identifying information of the participant.
2. **[Name of PSC program]** program assessments (GAIN, COMPAS, risk and needs, etc.).
3. **[Name of PSC program]** program behavior summaries and updates.
4. Treatment information, including assessments, attendance, progress and compliance reports, treatment plans, and discharge summaries.
5. Drug and alcohol screening, testing, confirmation results, and payment information.
6. Health information.
7. Reportable communicable disease information, including HIV, sexually transmitted infections, hepatitis, and tuberculosis.
8. Health plan or health benefits information.
9. Electronic monitoring information, including compliance and payment information.
10. Information required to obtain a restricted license through the ignition interlock program.[2]
11. Other (specify, if any): _____

[1] Choose the appropriate option

[2] This is not applicable to Mental Health Courts and should be removed from this form if being used for a mental health court

Note: I authorize all of the preceding information to be shared unless I indicate here, by number, one or more categories of information not to be shared: _____

PURPOSE OF USE AND DISCLOSURE

The purposes for the disclosures authorized by this form are:

1. To assist **[Name of observing court/agency]** in planning, implementation, or enhancement of their problem-solving court.
2. For the evaluation or audit of **[Name of PSC program].**
3. Other (please specify): _____.

REDISCLOSURE AND CONFIDENTIALITY

Once health care information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 CFR, Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing information to others. However, substance-abuse treatment information protected by federal law (42 CFR, Part 2), shall remain confidential and must not be re-disclosed by the recipient except as authorized by those laws or this authorization[3]. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT EXPIRATION

The date, event, or condition upon which consent expires must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

This consent for release of information shall expire on **[date of the day following observed staffing].**

REVOCATION

I understand that I may revoke this consent, orally or in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that I do not have to fill out this form. If I do not fill it out I can still get health insurance, and treatment and other medical benefits from a health care provider.

[3] An individual within the criminal justice system who receives patient information under 42 CFR § 2.35 may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

I also understand that if I refuse to consent to disclosure, or attempt to revoke my consent prior to the expiration of this consent such action is grounds for immediate termination from the **[Name of PSC program]** program.

SIGNATURE CONSENTING TO RELEASE OF INFORMATION

Participant signature	Date
Staff witness signature	Date
Staff witness printed name	