



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

I, _____, hereby consent to communication between (Print Participant Name - subject of PHI)

ATTIC Correctional Services, Inc. (ACS) and individual/agency/entity to whom PHI may be disclosed and I authorize redisclosure between ACS and the parties named here:

(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 justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my assessment /diagnosis/initial screening, treatment plan(s), progress and compliance, treatment session, attendance, prognosis, discharge plan and status, urinalysis and breathalyzer results, and any other pertinent treatment information:

Your Rights With Respect To This Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my PHI including but not limited to: Mental Health -Sec. 51.30, Wis. Stats; & HFS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse -Sec. 51.30 Wis. Stats, HFS 92, Wis. Admin. Code; Minnesota Statute 144.335; and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Right to Receive a Copy of This Authorization: I have a right to receive a copy of this form after I sign it. Right to Refuse to Sign This Authorization: I am under no legal obligation to sign this form however, under certain circumstances permitted under applicable law; refusal to sign may result in denial of services. Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosures of my PHI made prior to receipt of my withdrawal statement. Re-disclosure: If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential. Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies.

INITIAL ONLY ONE I understand that this authorization will remain in effect and cannot be revoked by me until:

- There has been a formal and effective termination or revocation of my probation, parole, conditional release or other proceeding under which I was mandated into treatment.
Authorization expires 12 months from the date I sign this authorization.
Authorization expires after the following action occurs:

I have read or had read to me the contents of this authorization. I have had an opportunity to discuss and ask questions. By signing this authorization, I am confirming that it accurately reflects my wishes regarding disclosures of my PHI. A photocopy, fax or electronic image of this authorization shall be as valid as the original.

Signature of Participant Who is Subject of PHI Date Signed

Signature of Other Person Legally Authorized to Consent to Disclosure (If Applicable) / Title or Relationship To Individual Who Is Subject of PHI Date Signed