



WAIVER AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

HENRY COUNTY RESOURCE COURT (HCRC)

I, \_\_\_\_\_, Social Security Number, \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, Date of Birth, \_\_\_\_\_, Case Number, \_\_\_\_\_, hereby request and authorize the Henry County Resource Court (HCRC) to obtain records from the following agencies:

INCLUDES ALL - DO NOT CIRCLE - ADD OTHER PARTIES NOT INCLUDED - MH, FAM. MD, ETC.

- Henry County Jail - Correct Health
Henry County Health Department
Henry Medical Center
Henry County School System
Social Security Administration
Worktech
Georgia Department of Labor
Riverwoods
Veterans Administration
McIntosh Trail Community Service Board
Pine Woods Crisis Stabilization Unit
Henry County Department of Family and Children Services
Southern Regional Hospital
Clayton Center
GA Division of Behavioral Health and Developmental Disabilities
Southern Crescent Behavioral Health Systems

The information so obtained will be used by the Henry County Henry County Resource Court (HCRC) for the purposes of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring compliance with the treatment program, including informing the Court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis and completion of treatment. The extent of the information to be disclosed is as follows:

- Dates of Hospitalization
Discharge Summary
Medical History
Diagnosis
Lab Reports
Hepatitis History
Psychiatric Evaluation
Psychological Reports
Social History
Treatment Plan
HIV/AIDS History
Other:
Progress / Activity Notes
Nursing Assessment
Correspondence
Administrative/Legal Documents
Tuberculosis History

By signing this Authorization I hereby waive any privileges with respect to any information released to HCRC which may include mental health, mental illness, mental retardation, and/or substance abuse information. I hereby consent to the release of information for court monitoring and case management services related to discharge planning and social services benefits. I further consent to the release information for primary care services related to diagnosis, treatment, evaluation and follow-up.

By signing below I hereby release the HCRC, its officers, agents and employees from any and all liabilities, damages, and claims which might arise from the release of information authorized above. I understand that this consent remains in effect until three years following completion of the HCRC program (completion, withdrawal or dismissal). I consent for my criminal history to be checked for five years following my completion, withdrawal or dismissal from HCRC for the purpose of follow-up, research, and program evaluation. I understand I may withdraw my consent at any time with written notification, but any information released prior to the withdrawal of consent remains authorized.

IMPORTANT: I understand that my alcohol and/or treatment records and behavior health treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written authorization unless otherwise provided for that regulation. HIV/AIDS information may not be redisclosed without my written authorization.

Print Name Signature of Defendant Date

Print Name Signature of Attorney Date

Please remit medical records to: Henry County Resource Court, 140 Henry Parkway, McDonough, GA 30253 Phone #: 770-288-7591 Fax #: 770-288-7594