WAIVER AND CONSENT FOR THE RELEASE AND COMMUNICATION OF CONFIDENTIAL INFORMATION

HENRY COUNTY RESOURCE COURT (HCRC)

I, ____, Social Security Number, ________-_______-________,

Date of Birth, ________________________________, Case Number, ______________________, hereby consent to the release of all treatment records and communication among the following groups:

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

- Henry County Superior Court
- Henry County State Court
- Henry County Magistrate Court
- McDonough Probation Office
- Felony Probation / GDC
- Henry County Sherriff's Office
- Henry County Police Department
- McIntosh Trail Community Service Board
- Henry Medical Center
- Henry County School System
- Henry County DUI/Drug Court
- Southern Crescent Behavioral Health Systems
- ______________________________________
- ______________________________________
- Henry County District Attorney's Office
- Henry County Solicitor's Office
- Henry County Probate Court
- Sentinel Probation
- Henry County Jail - Medical Services (Correct Health)
- Henry County Public Defender's Office
- Lister & Holt (State Court Public Defender)
- Evaluator approved by Court for Research Analysis
- Locust Grove, Hampton and McDonough City Police Departments
- Locust Grove, Hampton, McDonough and Stockbridge City Courts
- Henry County Health Department
- Riverwoods Behavioral Health
- Henry County Department of Family and Children Services
- ____

I understand that by participating in the HCRC, I am waiving any privacy protections that may apply to my treatment and other records as set out in this release. This communication is regarding any and all information requested pertaining to me, to include, but will not be limited to information obtained through GCIC and/or NCIC record checks, and information concerning mental health, substance use, drug testing, diagnosis and treatment. I understand that my attorney may take part in such communications.

I further authorize any prison, county jail or city jail in which I have been confined to release to the Court all information in my records concerning tests for HIV (AIDS), Tuberculosis and Hepatitis.

The above information will be used by the HCRC for the following purposes: (a) to coordinate treatment services; (b) to provide referral information; and (c) to monitor compliance with a treatment program, including informing the Court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress and completion of treatment.

I understand that the HCRC operates by a team philosophy and authorize members of the Court, treatment providers, probation, the Henry County Sheriff's Department/Jail, the District Attorney's office, Solicitor's Office, and my defense attorney to routinely discuss my case, my progress and other information regarding my treatment and/or case.
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 further understand that I can withdraw this consent, by issuing a letter in writing, at anytime prior to the expiration, but any information released prior to the withdraw of consent remains authorized.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and/or drug abuse, and the recipients of this information may disclose it only in connection with their official duties. This release is intended to comply with all laws of the State of Georgia and all provisions of HIPPA (45 C.F.R. Parts 160 & 164).

______________________	______________________	__________
Print Name	Signature of Defendant	Date
______________________	______________________	__________
Print Name	Signature of Attorney	Date