PeaceWay Counseling & Mediation Services, Inc.
2405 Bemiss Road, Valdosta GA 31602 / phone (229) 333-2351 / fax(229)333-2353

## CLIENT DEMOGRAPHICS

**Name:** _____

**DOB:** _____ **Gender:** _____ **Race:** _____

**Social Security Number:** _____ **Email:** _____

**Telephone Number: Cell** _____ **Home:** _____

**Street Address:** _____

**City, State, Zip Code:** _____

**Probation Office:** _____ **Probation Officer:** _____

**Marital Status: Never Married** ____ **Married** _____

**Divorced:** _____ **Widowed:** _____

**Employment Status: Employed** ____ **Unemployed** _____ **Disabled** _____

**Full-time Student:** _____ **Retired** _____

**Emergency Contact:** _____ **Ph:** _____

**Armed Forces Veteran: Yes** _____ **No** _____

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# CLINICAL EVALUATION STATEMENT OF UNDERSTANDING CONTRACT

- The Clinical Evaluation will be valid for sixty (60) days from evaluation date.
- Clinical evaluations shall be maintained for six (6) years.

I have read and understand the terms of this agreement. I have received a copy of the contract.

_____ _____
*Client Signature* *Date*

_____ _____
*Clinical Evaluator Signature* *CE#* *Date*

**2405 Bemiss Road**
**Valdosta, GA 31602**

**Phone 229-333-2351**
**Fax 229-333-2353**
**contactus@peacewaycms.com**

## ALL FIRST DUI OFFENDER CLIENTS - PLEASE READ CAREFULLY

*Revised October 2019*

First time DUI offenders are required, as a condition of probation, to get a clinical evaluation, and if indicated by the evaluation, complete a substance abuse treatment program. These requirements, effective July 1, 2008 are in addition to all other existing requirements for probation. Under this new law, the Department of Behavioral Health and Developmental Disabilities (DBHDD) is responsible for approving clinical evaluators and treatment providers and establishing regulations for implementing these requirements.

DUI RISK REDUCTION PROGRAM

- ☐ It is best that you complete the DUI Risk Reduction program (DUI School of 20 hours of classroom instruction) before getting the clinical evaluation.

CLINICAL EVALUATION

- ☐ The clinical evaluation consists of a clinical interview, a review of your NEEDS Assessment results from the DUI school, and any other assessment instruments deemed appropriate by the evaluator to complete a thorough evaluation. Only an approved evaluator from the DBHDD Registry of Clinical Evaluators can complete your clinical evaluation.
- ☐ You will be given a Clinical Evaluation Agreement / Contract that informs you of the services you are entitled to as part of the evaluation process, including a free copy of your evaluation.
- ☐ If the evaluation results in a treatment recommendation, the clinical evaluator must show you a list of approved providers (DBHDD Registry of Treatment Providers).
- ☐ The evaluator will recommend a level of care.
- ☐ The evaluator cannot tell you to go to a specific treatment provider, you decide that.
- ☐ The evaluator cannot determine the exact number of weeks you have to attend treatment.
- ☐ If the evaluator determines there is no need for treatment, the evaluator will provide a summary letter to that effect, which can be submitted to your Probation Officer.

TREATMENT:

- ☐ You must choose a treatment provider from the DBHDD Registry of Treatment Providers who is permitted to deliver the ASAM level of care recommended by the clinical evaluator.
- ☐ NOTE: As part of a court order, only a judge can tell you to go to a particular treatment program. However, if a judge orders you to go to a treatment program not on the DBHDD Registry, completion of that treatment may not count toward driver's license reinstatement.
- ☐ ASAM Level I – Short Term Program is 6-12 weeks, 18 hours minimum.
- ☐ ASAM Level I long-term program is three to nine hours of treatment services per week. The length of treatment is 4 to 12 months. A treatment review occurs when 4 months has been completed. A decision will then be made for you to continue with more counseling or that you have completed the treatment program.
- ☐ You will be given a Treatment Agreement / Contract that informs you all requirements for successful completion of the program.
- ☐ It is the responsibility of the treatment provider to determine the length of treatment and the number of hours you must attend. You may be expected to attend more than the minimum number of hours and weeks of treatment.
- ☐ The treatment program may have additional requirements to be met before you are considered as having completed treatment. Each individual treatment provider or agency determines additional services.
- ☐ Finally, you must have satisfied all fees to the treatment provider in order to receive your "Treatment Completion" form, which can be submitted to your probation officer.

_____ _____

*Client Signature* *Date*

## ALL MULTIPLE DUI OFFENDER CLIENTS - PLEASE READ CAREFULLY

*Revised October 2019*

Multiple DUI offenders who get two or more DUI offenses within a 10-year period are required, as a condition of license reinstatement, to get a clinical evaluation, and if indicated by the evaluation, complete a substance abuse treatment program. These requirements, effective July 1, 2008, are in addition to all other existing requirements for license reinstatement. Under this law, the Department of Behavioral Health & Developmental Disabilities (DBHDD) is responsible for approving clinical evaluators and treatment providers and establishing regulations for implementing these requirements.

DUI RISK REDUCTION PROGRAM

- ☐ It is best that you complete the DUI Risk Reduction program (DUI School of 20 hours of classroom instruction) before getting the clinical evaluation.

CLINICAL EVALUATION

- ☐ The clinical evaluation consists of a clinical interview, a review of your NEEDS Assessment results from the DUI school, and any other assessment instruments deemed appropriate by the evaluator to complete a thorough evaluation. Only an approved evaluator from the DBHDD Registry of Clinical Evaluators can complete your clinical evaluation.
- ☐ You will be given a Clinical Evaluation Agreement / Contract that informs you of the services you are entitled to as part of the evaluation process, including a free copy of your evaluation.
- ☐ If the evaluation results in a treatment recommendation, the clinical evaluator must show you a list of approved providers (DBHDD Registry of Treatment Providers).
- ☐ The evaluator can only recommend a specific level of care.
- ☐ The evaluator cannot tell you to go to a specific treatment provider.
- ☐ The evaluator cannot determine the number of weeks you have to attend treatment.
- ☐ If the evaluator determines there is no need for treatment, the evaluator will submit a case presentation to DBHDD for review.
- ☐ If approved, DBHDD will provide the client with a "Requirements Met" certificate, which can be submitted to the Department of Driver Services (DDS) for license reinstatement.

TREATMENT:

- ☐ You must choose a treatment provider from the DBHDD Registry of Treatment Providers who is permitted to deliver the ASAM level of care recommended by the clinical evaluator.
- ☐ NOTE: As part of a court order, only a judge can tell you to go to a particular treatment program. However, if a judge orders you to go to a treatment program not on the DBHDD Registry, completion of that treatment may not count toward driver's license reinstatement.
- ☐ DBHDD requires that Level I services include three to nine hours of treatment services per week. The length of treatment is up to one year. A treatment review occurs when 4 months has been completed. A decision will then be made for you to continue with more counseling or complete the treatment program.
- ☐ You will be given a Treatment Agreement / Contract that informs you all requirements for successful completion of the program.
- ☐ It is the responsibility of the treatment provider to determine the length of treatment and the number of hours you must attend. You may be expected to attend more than the minimum number of hours and weeks of treatment.
- ☐ The treatment program may have additional requirements to be met before you are considered as having completed treatment. Each individual treatment provider or agency determines additional services.
- ☐ Finally, you must have satisfied all fees to the treatment provider in order to receive your "Treatment Completion" form, which can be submitted to DDS for license reinstatement.

_____ _____

*Client Signature* *Date*

# DUI INTERVENTION PROGRAM

## ALL CLIENTS

*Revised October 2017*

### IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The purpose of the Risk Reduction Program is to help people who have experienced a problem because of their use of alcohol or other drugs. Your DUI, drug possession, or other charge may not be the first time you have had a problem because of your use of alcohol or drugs. The program will teach you how to reduce your chances of having future alcohol or drug related problems.

### COMPLETION OF THE DUI, ALCOHOL OR DRUG RISK REDUCTION PROGRAM

Some offenses that require completion of the DUI, Alcohol or Drug Risk Reduction Program (DUI SCHOOL) are DUI, Drug Possession, and Underage Alcohol Possession While Operating a Vehicle. Judges will sometimes order people to attend the Risk Reduction Program for other offenses. At the Risk Reduction Program you will take an assessment, and attend a 20-hour Intervention course. The results of your assessment are confidential, and will not appear on your driving record. You will learn about your assessment results during class. If you have questions, please talk to your Instructor after you begin class.

It is against the law for anyone to tell you that you have to attend a particular DUI Risk Reduction Program (DUI school). A Judge or Probation Officer may require you to bring proof that you completed the DUI School, but they cannot tell you which school you have to attend.

### IF YOU HAVE RECEIVED 2 OR MORE DUI'S IN THE PAST 10 YEARS

If you have a DUI arrest after 7-1-08, the law requires persons who have received 2 or more DUI in a ten-year period to get a substance abuse clinical evaluation and if necessary, complete a treatment program in order to regain their driver's license. For arrests prior to 6-30-08, the period is five years.

### IF YOU ARE FIRST TIME DUI OFFENDER

For DUI arrests after 7-1-08, all first DUI offenders are required to have a clinical evaluation and complete treatment if recommended as a standard condition of probation unless specifically waived by the judge for first offenders.

### FOR ALL DUI'S

You must get a clinical evaluation before or after you complete DUI School. This clinical evaluation is different from the assessment questionnaire you completed at the Risk Reduction Program. The Evaluator is a substance abuse professional who will interview you in person. If available, he/she will have the results of your assessment survey from the DUI School to review before meeting with you. The Risk Reduction Program will provide you with the registry from the Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) listing all approved Evaluators in your area. You may choose any Evaluator on the registry. After you choose an Evaluator, you will need to sign a Release of Information form and pay up to a $25.00 transfer fee so that the Risk Reduction Program can send a copy of your assessment to the Evaluator. The costs for each Evaluator are listed on the registry, and start at $110.00. Some Risk Reduction Programs may have a Clinical Evaluator available, but you are not required to get your clinical evaluation at their facility.

After completing the clinical evaluation, the Evaluator may recommend that you attend a Treatment Program. The Clinical Evaluator will make a recommendation for the level of service you need and give you a DBHDD -approved registry of treatment providers in your area. The Evaluator and the Risk Reduction Program cannot refer you to a particular Treatment Provider; that is your responsibility. In addition, you cannot receive treatment services from the person who does your clinical evaluation. If you have someone in mind for treatment, do not select that person for your clinical evaluation.

NOTE: To be eligible for driver's license reinstatement, you have to go to a Clinical Evaluator and Treatment Provider that are on the DBHDD-approved registry.

*I have read the above information, or the program has read it to me. I have received a copy of this form.*

_____ _____

Student Signature Date

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# Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

The patient consents in writing;

The disclosure is allowed by a court order; or

The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

**Source:** "Confidentiality of Alcohol and Drug Abuse Patient Records" *Code of Federal Regulations,* 2000. 42 CFR, chapter I, part 2,

Client Signature _____ Date _____

Staff Signature _____ Date _____

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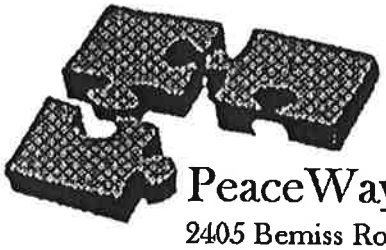
## CAGE ASSESSMENT

1. Have you felt the need to ***Cut Down*** on your drinking?

2. Do you feel ***Annoyed*** by people complaining about your drinking?

3. Do you feel ***Guilty*** about your drinking?

4. Do you ever drink an ***Eye-Opener*** in the morning to relieve shakes?



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2405 Bemiss Road, Valdosta, GA 31602

**Drug Abuse Screening Test**

1. **Have you used drugs other than those required for medical reasons?**

   ☐ **Yes**
   ☐ **No**

2. **Have you abused prescription drugs?**

   ☐ **Yes**
   ☐ **No**

3. **Do you abuse more than one drug at a time?**

   ☐ **Yes**
   ☐ **No**

4. **Can you get through the week without using drugs?**

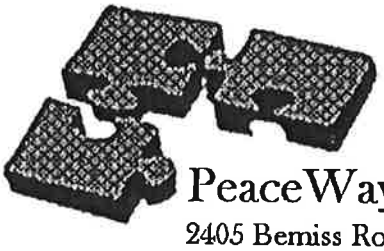
   ☐ **Yes**
   ☐ **No**

5. **Are you always able to stop using drugs when you want to?**

   ☐ **Yes**
   ☐ **No**

6. **Have you had "blackouts" or "flashbacks" as a result of drug use?**

   ☐ **Yes**
   ☐ **No**



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7. **Do you ever feel bad or guilty about your drug use?**

   ☐ **Yes**
   ☐ **No**

8. **Does your spouse (or parents) ever complain about your involvement with drugs?**

   ☐ **Yes**
   ☐ **No**

9. **Has drug abuse created problems between you and your spouse or your parents?**

   ☐ **Yes**
   ☐ **No**

10. **Have you lost friends because of your use of drugs?**

    ☐ **Yes**
    ☐ **No**

11. **Have you neglected your family because of your use of drugs?**

    ☐ **Yes**
    ☐ **No**

12. **Have you been in trouble at work because of your use of drugs?**

    ☐ **Yes**
    ☐ **No**

13. **Have you lost a job because of drug abuse?**

    ☐ **Yes**
    ☐ **No**

14. **Have you gotten into fights when under the influence of drugs?**

    ☐ **Yes**
    ☐ **No**

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**15. Have you engaged in illegal activities in order to obtain drugs?**

- ☐ Yes
- ☐ No

**16. Have you been arrested for possession of illegal drugs?**

- ☐ Yes
- ☐ No

**17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

- ☐ Yes
- ☐ No

**18. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?**

- ☐ Yes
- ☐ No

**19. Have you gone to anyone for help for a drug problem?**

- ☐ Yes
- ☐ No

**20. Have you been involved in a treatment program especially related to drug use?**

- ☐ Yes
- ☐ No

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## Michigan Alcohol Assessment Test

1. **Do you feel you are a normal drinker? ("normal"–drink as much or less than most other people)?**

   ☐ Yes
   ☐ No

2. **Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?**

   ☐ Yes
   ☐ No

3. **Does any near relative or close friend ever worry or complain about your drinking?**

   ☐ Yes
   ☐ No

4. **Can you stop drinking without difficulty after one or two drinks?**

   ☐ Yes
   ☐ No

5. **Do you ever feel guilty about your drinking?**

   ☐ Yes
   ☐ No

6. **Have you ever attended a meeting of Alcoholics Anonymous (AA)?**

   ☐ Yes
   ☐ No

7. **Have you ever gotten into physical fights when drinking?**

   ☐ Yes
   ☐ No

8. **Has drinking ever created problems between you and a near relative or close friend?**

- ☐ **Yes**
- ☐ **No**

9. **Has any family member or close friend gone to anyone for help about your drinking?**

- ☐ **Yes**
- ☐ **No**

10. **Have you ever lost friends because of your drinking?**

- ☐ **Yes**
- ☐ **No**

11. **Have you ever gotten into trouble at work because of drinking?**

- ☐ **Yes**
- ☐ **No**

12. **Have you ever lost a job because of drinking?**

- ☐ **Yes**
- ☐ **No**

13. **Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?**

- ☐ **Yes**
- ☐ **No**

14. **Do you drink before noon fairly often?**

- ☐ **Yes**
- ☐ **No**

15. **Have you ever been told you have liver trouble such as cirrhosis?**

- ☐ **Yes**
- ☐ **No**

16. **After heavy drinking have you ever had delirium tremors (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?**

- ☐ **Yes**
- ☐ **No**

**17. Have you ever gone to anyone for help about your drinking?**

- ☐ Yes
- ☐ No

**18. Have you ever been hospitalized because of drinking?**

- ☐ Yes
- ☐ No

**19. Has your drinking ever resulted in being hospitalized in a psychiatric ward?**

- ☐ Yes
- ☐ No

**20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?**

- ☐ Yes
- ☐ No

**21. Have you been arrested more than once for driving under the influence of alcohol?**

- ☐ Yes
- ☐ No

**22. Have you ever been arrested, even for a few hours, because of other behavior while drinking?**

- ☐ Yes
- ☐ No

Georgia Department of Behavioral Health & Developmental Disabilities
Office of Addictive Diseases

# DUI INTERVENTION PROGRAM

## CLINICAL REFERRAL TRANSFER FORM TO TREATMENT PROVIDER

To: _____ TP User ID: _____
(Include: City, State, Zip) (Provider ID #)

Attached are the Case Presentation format and the release of information for clinical evaluation on the client listed below:

Client's Full Name: _____ _____
(Last, First, Middle) (Date of Birth)

Address: _____

_____

Certificate # _____ RRP Course Completion Date: _____
(RRP Certificate of Completion # if available) (RRP Completion Date if available)

Evaluator's Name: _____

Address: _____

Telephone #: (____) _____ CE User ID: _____

Date Evaluation Completed: _____

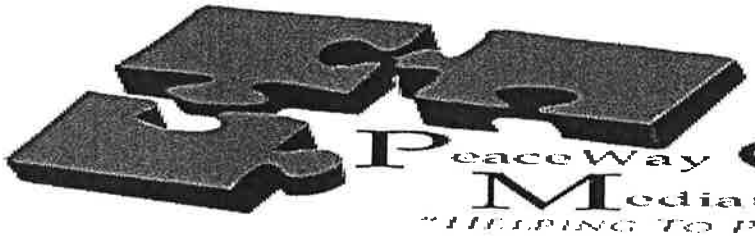
## ASAM Level of Treatment Referral to:

| | | | | | |
|---|---|---|---|---|---|
| Level I (6 - 12 weeks): | ☐ | Level I (4 - 12 months): | ☐ | Level II.1 | ☐ |
| Level II.5: | ☐ | Level III.1 | ☐ | Level III.3 | ☐ |
| Level III.5 | ☐ | Level III.7 | ☐ | Level IV | ☐ |
| OMT: | ☐ | | | | |

I hereby swear (or affirm) that this clinical evaluation was conducted by the undersigned in accordance with the rules of the Department of Behavioral Health & Developmental Disabilities, Chapter 290-4-13, and Georgia Law, O.C.G.A. Section 37-7-2

_____ _____
Clinical Evaluator Signature Date

TF: Attach this original form to front of Case Presentation




2405 Bemiss Road, Valdosta, Georgia 31602

## Clinical Evaluation Contract

Anyone who gets a DUI in Georgia is required to attend DUI School, have a clinical evaluation from a State approved Clinical Evaluator, and complete any treatment recommendations with a State approved Treatment Provider. These requirements, effective 7-1-1997 and 7-1-2008, are State law. The State approved evaluators and treatment providers can be found on the web at https://gaduiintervention.dbhdd.ga.gov/Home.aspx. Other conditions may be required for license reinstatement fees. Call the Department of Drivers Services at 678-413-8400 for information on your case.

- It is best that the client complete DUI School before having a clinical evaluation.
- The client will select a clinical evaluator from the State Registry and have the DUI School forward the NEEDS assessment to that evaluator.
- The client may select any evaluator they wish from the Registry.
- The client is entitled to a second opinion.
- The client will select a treatment provider from the State Registry. If this is not done within 60 days of the evaluation, the evaluator may conduct another evaluation.
- The client will pay the clinical evaluation fee of _____ in full at the time of service.
- Records shall be maintained for six (6) years.
- The Clinical Evaluator (CE) attests that they are currently on the State Registry of approved clinical evaluators.
- The CE will determine the level of treatment recommended not the place or length of treatment.
- The CE will show the client the list of State approved treatment providers on the Registry.
- The CE will forward the necessary forms and information to the selected treatment provider after the client signs the necessary release of information form.

I have read and understood the terms of this agreement. I have received a copy of the contract.

Client Signature _____ Date _____

Clinical Evaluator Signature _____ CE# _____ Date _____

(229) 333-2351 or (229) 333-2352 or Fax (229) 333-2353

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_____ My Clinical Evaluation was performed by _____.

_____ I select to attend PeaceWay Counseling Mediation Services under the provider, _____.

_____ _____
Clinical Evaluator Date

_____ _____
Client Date

2405 Bemiss Road
Valdosta, GA 31602

Phone 229-333-2351
Fax 229-333-2353
contactus@peacewaycms.com

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____ hereby authorize the disclosure of records/information

From: _____
(Name of DBHDD-approved **Clinical Evaluator** - releasing agency)

To: _____
(Name of DBHDD-approved DUI Intervention Program **Treatment Provider** )

_____ (Address) (Phone/Fax)

____ Initials I authorize the following information from my records (and any specific portion thereof): *All results of my clinical evaluation as shown on the DUI Offender Case Presentation form, including alcohol and drug abuse information, the NEEDS assessment and any other reports, test results, or documents used by the evaluator to complete my evaluation. AND*

____ Initials If I am a minor, my parent/guardian/court-ordered custodian and I both must initial here in order for this information to be released.

____ Initials I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

The above information is for the purpose of:

____*To permit transfer of my clinical evaluation record to the DUI Intervention Program Treatment Provider of my choice, for the purpose of my treatment.*

1. *I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for*

____Six (6) months after the completion of my clinical evaluation which occurred on _____ (date).

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.*

_____ _____
**Date** **Signature of Individual/Consumer/Patient/Applicant**

_____ _____
**Signature of (check one)** **Date**

☐ **Patient** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor**
☐ **Agent designated by Individual's Advanced Directive**

## USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

*I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142.*

_____ _____
**Date this authorization is revoked by Individual** **Signature of Individual or legally authorized Representative**

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____ hereby authorize the disclosure of records/information:

From: _____ (Name of DBHDD-approved **Clinical Evaluator** - releasing agency)

To: Dept. of Behavioral Health and Developmental Disabilities, Division of Addictive Diseases, **DUI Intervention Program**
2 Peachtree Street, Suite 22.286, Atlanta, GA 30303
FAX: 404-657-6417

_____ Initials I authorize the following information from my records (and any specific portion thereof): All results of my clinical evaluation as shown on the DUI Offender Case Presentation form, including alcohol and drug abuse information, the NEEDS assessment and any other information about my clinical evaluation requester by the DUI Intervention Program. **AND**

_____ Initials If I am a minor, my parent/guardian/court-ordered custodian and I both must initial here in order for this information to be released.

_____ Initials I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

The above information is for the purpose of: ____*Enabling the professional staff of the DBHDD Division of Addictive Diseases, DUI Intervention Program, and its agents to review and approve the recommendation of my Clinical Evaluator.*

_____

1. *I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for* ____six (6) months after the completion of my clinical evaluation which occurred on _____(date).

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.*

_____ _____
**Date** **Signature of Individual/Consumer/Patient/Applicant**

_____
**Signature of (check one)** **Date**

☐ **Patient** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor**
☐ **Agent designated by Individual's Advance Directive**

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