

BestCare Treatment Services
125 SW C Street
Madras, OR 97741
Phone: 541-475-6575
Fax: 541-475-6196

Release of Confidential Information

I, _____, whose date of birth is _____ hereby authorize BestCare Treatment Services to disclose and exchange information with:

JEFFERSON COUNTY MENTAL HEALTH COURT TEAM **
JEFFERSON COUNTY COURTHOUSE
129 SW E Street, Suite 101
Madras, Oregon 97741
541-475-6575 541-475-6196
(Telephone) (Fax)

THE FOLLOWING INFORMATION:
(Please initial items)
____ Assessment outcome, treatment plan,
enrollment & compliance.
____ Progress reports and termination summary
____ Aftercare recommendations, planning
____ Drug test results
____ Status report information and any
information needed to coordinate the
Mental Health Court case

THE PURPOSE OF NEED FOR SUCH DISCLOSURE:
(Please initial items)
____ Two-way communication between Mental Health
Court partners
____ Coordinate status hearings, services, etc.
as part of Mental Health Court Agreement

****Mental Health Court Team consists of the Jefferson County Circuit Court Judge, Jefferson County District Attorney or representative, Public Defenders, Mental Health Program representative, and other professional parties in the case (i.e. DHS)**

_____ **I give permission for a message to be left on my phone/answering machine concerning appointments.**

I understand that my records are protected under the Federal regulations (42 CFR Part 2) and cannot be disclosed without my written consent unless provided for in the regulations. By signing below I give my consent to the release of my drug and alcohol records. I also understand that I may, in writing, revoke this consent at any time except to the extent that disclosure was made prior to the time I revoked it.

I understand that authorizing the disclosure of this treatment information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not adversely affect my ability to receive treatment. I may inspect or copy the information used and/or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure of my treatment information.

CRIMINAL JUSTICE AND DUII CLIENTS: I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal termination of my probation, parole or from other Court mandated treatment.

I have read this authorization and I understand it. Unless revoked, this authorization expires 30 days after termination of treatment. Photocopies and electronic facsimile copies of the authorization are considered as valid as the original.

Client's Signature

Date

Witness Signature

Date