

DISP

DUII Intensive Supervision Program
1021 SW 4th Ave, Room 710
Portland, OR 97204
503-988-4221



Circuit Court of the State of Oregon
Fourth Judicial District
Multnomah County, Oregon

Honorable Judith H. Matarazzo
Honorable David F. Rees

Initial Release

DUII Intensive Supervision Program (DISP)

This form must be read, understood, and signed before entry into DISP

_____ / ____ / ____
Defendant's Full Name

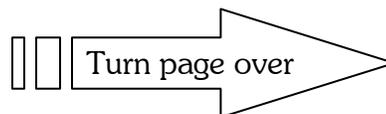
DOB

Case Number(s): _____

Every DISP Defendant must sign specific written authorizations for disclosure and mutual exchange of confidential substance abuse information, mental health information and other necessary medical information. The exchange of information allows the court to monitor defendant's treatment attendance, diagnosis, prognosis, compliance, and general compliance with the DISP Probation Conditions. The type and extent of the information disclosed will include only that information which is necessary to monitor compliance with the DISP Probation Conditions imposed in case(s) listed above.

Defendant's initials _____ I understand that information necessary to monitor probation compliance may be mutually exchanged between DISP and any or all of the following: Multnomah County Oregon Circuit Court; Multnomah County DUII Intensive Supervision Program (DISP) staff ; Oregon Judicial Department Court staff; Treatment Services Northwest staff; Vigilnet Northwest staff; Multnomah County Adult Community Justice Department; Multnomah County Sheriff's Office; ADES alcohol/drug evaluator; any polygrapher who examines defendant; any substance abuse treatment provider serving Defendant; any mental health treatment provider serving Defendant; any medical care facility or practitioner serving Defendant; any person listed by Defendant as an emergency contact.

Defendant's initials _____ I understand that confidential information may be disclosed in court proceedings, which are open to the public. Some Personally Identifying Information may be disclosed through court record keeping operations. I understand that Personally Identifying Information may be disclosed during public graduation or transfer ceremonies. I also understand that my personal information will be entered into a computerized database, and that information will be used by DISP to monitor my probation compliance. I hereby authorize disclosures under these circumstances.



I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. Any information that identifies me as a patient in a substance abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations. I also understand that recipients of confidential information may only redisclose confidential information in connection with official duties.

I understand that my treatment and medical records are protected under the federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that if my health information is disclosed pursuant to this signed authorization, the recipient of HIPAA protected information may redisclose, and it may no longer be protected by the HIPAA privacy law. However, 42 C.F.R., Part 2, noted above, will continue to protect the information that identifies me as a patient in a substance abuse program.

I understand that I can enter treatment for substance abuse whether or not I sign this release or any other authorization.

Defendant's Initials _____ I understand that I must disclose to any doctor or other prescribing medical professional that I am in a substance abuse treatment program before I receive prescription medications, especially pain killing medications. The court may require the doctor or prescriber to provide written acknowledgement that I am in a substance abuse program. I will not fill drug prescriptions without first speaking with my DISP Case Manager. Additionally, I agree that I will not seek narcotic pain medications as a means of replacing old drug behaviors.

I understand that my authorization for disclosure and exchange of information may be withdrawn, either orally or in writing, at any time, except to the extent that action has been taken in reliance on it.

Defendant's Initials _____ **I understand that if I withdraw this release before the end of probation, I may be removed from the program, my probation may be revoked and I might be sent to jail.**

This release shall remain valid until my probation is completed or terminated. My authorization will automatically expire when my probation expires, or has been revoked, or has been terminated for some other reason.

By signing this form, I certify that I have read the terms of this document and agree to these terms. I will execute all necessary future releases for disclosure and mutual exchange of information, as may be required for monitoring my probation in the DUII Intensive Supervision Program (DISP).

Defendant's Signature

Date