LANCASTER COUNTY DRUG AND ALCOHOL COMMISSION

Consent to Release Confidential Information

Lancaster County Prison Pre-Parole and Door to Door Referrals

Individual's FULL Legal Name: _____

Today's Date: _____

Date of Birth: _____

I, _____, do hereby consent to and authorize the **Lancaster County Drug and Alcohol Commission** to release relevant information to the following entities:

Please check all that apply:

☐ **Lancaster County Court of Common Pleas**, Sentencing Judge or Designate, 50 North Duke Street, Lancaster, PA 17608, Phone- 717-299-8041

☐ **Lancaster County Prison**, Reentry Program Designate, 625 East King Street, Lancaster, PA 17602, Phone- 717-299-7800

☐ **Lancaster County Prison**, Records Department Designate, 625 East King Street, Lancaster, PA 17602, Phone- 717-299-7800

☐ **Lancaster County Office of the District Attorney**, Assistant District Attorney Designate, 50 North Duke Street, Lancaster, PA 17608, Phone- 717-299-8100

☐ **Lancaster County Adult Probation & Parole Services**, Pre-parole Designate, 40 East King Street, Lancaster, PA 17608, Phone- 717-299-8181

☐ **Lancaster County Adult Probation & Parole Services**, Supervising Probation Officer Designate, 40 East King Street, Lancaster, PA 17608, Phone- 717-299-8181

☐ **Lancaster County Behavioral Health & Developmental Services**, Case Management Designate, 750 Eden View Road, Lancaster, PA 17601, Phone- 717-393-0421

☐ **Lancaster County Public Defender's Office**, Representing Attorney Designate, 150 North Queen Street, Lancaster, PA 17603, Phone- 717-299-8131

☐ **Donegal Substance Abuse Alliance**, Door to Door Placement Project Designate, 78 East Main Steet, Mount Joy, PA 17552; Phone 717-492-4596

☐ **Lancaster County Bail Administration,** Assigned Designate, 50 North Duke Street, Lancaster, PA 17603; Phone: 717-295-3584

☐ **Lancaster County Assistance Office,** Assigned Designate; 832 Manor Street, Lancaster, PA 17603; Phone: 717-299-7411

☐ Other (include name of agency/program; address; telephone number):

_____

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It has been explained to me and I am in agreement to permit the following specific information* to be disclosed (***there must be a detailed description of how much and what kind of information may be disclosed, including explicit description of SUD information to be disclosed, of which should be limited as possible**): _____

_____

Furthermore, it has been explained to me and I understand that the reason for the release of the information is solely for the purpose of *(***a detailed description of the* **reason** *of the disclose; should be as specific as possible)*:

☐ Coordinating my treatment efforts

**Explain in detail: _____

☐ Coordination of and status report of my identified treatment-related needs

**Explain in detail: _____

☐ Other

**Explain in detail: _____

I understand that the information being disclosed is from the records in which the confidentiality of its contents is protected by Federal Regulation 42 CFR, Part 2. Federal Regulation 42 CFR, Part 2 prohibits any further disclosure, unless further disclosure is expressly permitted by ***MY written consent****, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is not sufficient for this purpose.*

I understand that I may revoke this consent at any time by notifying (verbally or in writing) a LCDAC staff or designate, except to the extent that action has been taken in reliance of my consent AND/OR, when applicable, if I am a client of the criminal justice system in which there has been a formal action by a Judge or documentation that the DA is putting me on ARD AND where copies of the legal order that state I must be in treatment to continue under such a disposition are in my client record, then and only then, federal regulations 42 CFR Part 2, Subpart C, 2.35, stipulate that I cannot revoke the consent to release drug & alcohol treatment information to the criminal justice system until after the court stipulated condition has been met.

As indicated in my RIGHTS as an individual involved in the SUD treatment system, I understand that whenever this consent is utilized, documentation of the exchange of information shall be made of which every effort shall ensue to inform me of the exchange. Furthermore, I may inquire at any point about said exchange of information.

I understand that if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, that services may be denied. If, however, I refuse to consent for any other purposes, I will NOT be denied services.

_____ _____

Individual's Signature Date

Expiration Date: _____ *(Specify date, event, or conditions; cannot be longer than reasonably necessary to serve the purpose of the consent)*

Check appropriate box: ☐ I have accepted a copy of this document ☐ I have declined a copy of this document

 Individual's Name: _____ **DOB:** _____