



WAIVER AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

TIFTON JUDICIAL CIRCUIT

ACCOUNTABILITY COURT-Tift, Worth, and Irwin County Adult Felony Drug Court programs

I, _____, Social Security Number, _____ - _____ - _____,

Date of Birth, _____, Case Number, _____, hereby request and authorize the Tifton Circuit Accountability Courts (TCAC) to obtain records from the following agencies:

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

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| ▪ Tifton Circuit Superior Court | ▪ Legacy Behavioral Health Community Service Board |
| ▪ Tift, Irwin, Worth, and Turner Magistrate Courts | ▪ Aspire Behavioral Health Community Service Board |
| ▪ Tift, Irwin, Worth, and Turner Juvenile Courts | ▪ Tift, Turner, Worth, and Irwin County Department of Family and Children Services |
| ▪ Georgia Dept. Community Supervision | ▪ Southwell Regional Hospital |
| ▪ City of Tifton Police Department | ▪ Tift, Turner, Worth, and Irwin County Sheriff's Departments/Jails |
| ▪ City of Ashburn Police Department | ▪ GA Division of Behavioral Health and Developmental Disabilities |
| ▪ Georgia Department of Labor | ▪ Tift, Turner, Worth and Irwin Probate Court |
| ▪ City of Sylvester Policy Department | ▪ City of Ocilla |
| ▪ Veterans Administration | ▪ Georgia Department of Driver Services |

The information so obtained will be used by the Tifton Circuit Accountability Court (Adult Felony Drug Court) for the purposes of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring compliance with the treatment program, including informing the Court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis and completion of treatment. The extent of the information to be disclosed is as follows:

- | | | |
|----------------------------|--------------------------|----------------------------------|
| ▪ Dates of Hospitalization | ▪ Psychiatric Evaluation | ▪ Progress / Activity Notes |
| ▪ Discharge Summary | ▪ Psychological Reports | ▪ Nursing Assessment |
| ▪ Medical History | ▪ Social History | ▪ Correspondence |
| ▪ Diagnosis | ▪ Treatment Plan | ▪ Administrative/Legal Documents |
| ▪ Lab Reports | ▪ HIV/AIDS History | ▪ Tuberculosis History |
| ▪ Hepatitis History | ▪ Other: _____ | |

By signing this Authorization I hereby waive any privileges with respect to any information released to TCAC which may include mental health, mental illness, and/or substance abuse information. I hereby consent to the release of information for court monitoring and case management services related to discharge planning and social services benefits. I further consent to the release information for primary care services related to diagnosis, treatment, evaluation and follow-up.

By signing below I hereby release the TCAC, its officers, agents and employees from any and all liabilities, damages, and claims which might arise from the release of information authorized above. I understand that this consent remains in effect **until three years following completion of the program** (completion, withdrawal or dismissal). I consent for my criminal history to be checked for five years following my completion, withdrawal or dismissal from the program for the purpose of follow-up, research, and program evaluation. I understand I may withdraw my consent at any time with written notification, but any information released prior to the withdrawal of consent remains authorized.

IMPORTANT: I understand that my alcohol and/or treatment records and behavior health treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written authorization unless otherwise provided for that regulation. HIV/AIDS information may not be redisclosed without my written authorization.

Print Name

Signature of Defendant

Date

Print Name

Signature of Attorney

Date

Please remit medical records to: Tifton Circuit Accountability Court, P.O. Box 1369, Tifton, GA 31794 Phone #: 229.386.7879
Fax #: 229.386. 7977 Email: tiftoncircuitnewlifecourts@gmail.com