SANTA CLARA COUNTY CRIMINAL JUSTICE SYSTEM REFERRAL
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby consent to communication between the following criminal justice agencies, treatment, and recovery programs:

- The Superior Court (including Drug Treatment Court), Adult Probation Department, my defense attorney(s), District Attorney's Office, Pretrial Services, Department of Correction; Criminal Justice History Information Systems (local and State) and
- Any County or private provider of alcohol or substance abuse treatment or recovery services.

The purpose of the exchange of information is to inform the criminal justice agencies of my eligibility, attendance and progress in alcohol/substance abuse treatment or recovery, and to determine whether treatment is effective (outcome evaluation). The extent of information to be disclosed is all information necessary to monitor my participation and compliance with treatment or recovery including my assessment information, recommended treatment plan, admission, status and drug testing information, attendance, my cooperation with the treatment program, and information necessary for determining effectiveness of treatment or outcome evaluation. Any information related to effectiveness of treatment or outcome evaluation will be reported in a statistical format only, and will not be used in criminal proceedings.

I understand that this consent will remain in effect and cannot be withdrawn until supervision by Pretrial Services is terminated. This date represents the date of my release from confinement, probation, parole, or other proceeding under which I was mandated into treatment in Case/Docket/Information Number _____.

Any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and recipients of this information may redisclose it only in connection with their official duties.

_____ _____
Defendant's Signature Dated

Print Name _____Date of Birth _____PFN Number _____

EXCHANGE OF INFORMATION BETWEEN TREATMENT PROVIDERS:

In order to facilitate my treatment by providers of substance abuse, medical or psychiatric/psychological treatment, I specifically consent to allow communication between all of my treatment providers for my benefit for the period specified in the Criminal Justice Consent Form. This exchange applies to my providers only.

Dated: _____ _____
Admin/forms/consent release Signature of defendant/patient/authorized representative