AXIS Health System

Consent to Release Part 2 Information

Authorization to Use and Disclose Part 2 Protected Health Information

Consent to Disclose Substance Use Disorder Records to the Criminal Justice System

Patient Information

Patient Name: _____ **Date of Birth**: _____

Phone/Email: _____ **Email**: _____

Authorized Recipient(s)

I authorize Axis Health System to disclose my substance use disorder (SUD) treatment records to the following criminal justice system (CJS) entities involved in my supervision or legal proceedings:

☐ anyone actively part of my court, diversion, or monitoring team and need treatment updates to fulfill their role

OR

☐ courts ☐ probation/parole officers ☐ public defender ☐ district attorney ☐ diversion program

Purpose of Disclosure

This disclosure is made for the purpose of monitoring my compliance with the terms of my criminal justice involvement, including treatment participation, progress, and outcomes.

What Information Will Be Shared

The following information may be disclosed:

- Dates of admission and discharge
- Treatment progress and compliance
- Drug and alcohol screening results
- Attendance and participation in treatment
- Recommendations for continued care or discharge
- Any other relevant information necessary for monitoring compliance

Redisclosure Notice

I understand that my SUD records are protected under federal law (42 CFR Part 2). Once disclosed to the authorized CJS entity, they **may not be further disclosed** without my written consent unless otherwise permitted by law.

Revocation of Consent

I understand that I **may not revoke** this consent until the expiration event occurs, as permitted under **42 CFR § 2.35**, because the disclosure is made to a CJS entity that has a lawful need to monitor my treatment as part of my legal status.

Expiration of Consent

This consent will expire on:

☐ [Insert specific date] _____

☐ Upon completion of my criminal justice supervision

☐ Upon discharge from the treatment program

☐ Other: _____

Patient Acknowledgement

I have read and understand this consent form. I voluntarily authorize the disclosure of my SUD records to the listed criminal justice system entities for the stated purpose.

I understand:

- I may request a copy of this form at any time, and a copy of this form is as valid as the original.
- Substance use program records protected by 42 CFR Part 2 may not be used or disclosed for civil, criminal, administrative, or legislative proceedings against me without my written consent or a court order.
- Records disclosed under this form may include information related to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV, behavioral or mental health services, and treatment of alcohol or drug use.
- **By signing below, I am affirming that I am allowed (have legal authority) to sign on my own or on behalf of the patient. I may be asked for documentation to verify my authority to sign this form.**

_____ _____

Signature of patient/legal guardian/personal representative Date

_____ _____

Printed name (if signing on behalf of patient) Relationship to patient (**required** if signing on behalf of patient)

Corporate Office-Health Information Management

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