



STATE OF RHODE ISLAND JUDICIARY

SUPERIOR COURT

RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

Case Number: _____

Address: _____

Date of Birth: _____

Case Manager: _____

I, _____, authorize the Diversion Program Case Coordination Providers and their Direct Service Provider agents, my current and prior schools, my employer, my treatment provider(s), and any other person or agency in possession of employment, medical, psychiatric, treatment, educational, mental health, or other documents and records which are deemed necessary for Diversion Program purposes, to release such information to the judicial officer or designee(s) from the:

**Rhode Island Superior Court
Diversion Program
250 Benefit Street
Providence, RI 02903
Telephone: (401) 222-8391 Facsimile: (401) 654-4149**

The requested information is necessary for the court to make an initial determination as to my eligibility for substance abuse and/or mental health treatment services and is also required on an ongoing basis to track my progress with the Diversion Program conditions. The free flow of information is vital to the success of the Diversion Program, and I voluntarily consent to the release and re-release of information which is considered necessary for Diversion Program purposes. I understand that any information gathered by the aforementioned individuals and agencies, including the Diversion Program Case Coordination Provider and the Direct Service Provider(s), will be re-released to the Diversion Program for court purposes. I further understand that the information gathered by the Diversion Program department may be re-released to all necessary individuals and agencies. (Alcohol, drug, and mental health records include all aspects of diagnosis, treatment, and prognosis. Educational records include all attendance, special service, behavioral, and academic progress reports).

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires one (1) year after the date signed, unless an earlier date is specified by a formal and effective termination of my involvement with the Diversion Program. Termination from the Diversion Program will occur upon the discontinuation of all court supervision as a result of either the successful completion of the Diversion Program requirements or upon discharge for violating the terms of the Diversion Program. The Diversion Program will inform the disclosing agency of the revocation or expiration of consent.

I understand that this is a limited disclosure for the purposes as stipulated above and any disclosure is bound by 42 C.F.R. Part 2, which governs the confidentiality of substance abuse patient records. The federal rules prohibit further disclosure of this information unless such a disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. It is a crime to violate this federal confidentiality requirement, which the participant may report to the appropriate authorities. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. However, federal law does not protect information relating to crimes committed on the premises of the program, crimes against program personnel, or the abuse or neglect of a child.

Signature of Participant

Date

Witness - Diversion Program Case Manager

Date