

New Mexico Treatment Court
Participant Release of Information and Consent Form

Treatment Court Case No. _____

Participant Name: _____ Year of Birth: _____ SSN (last 4 digits only): _____

This notice describes how medical and drug and alcohol-related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I _____ hereby authorize the _____ (Program Name) Treatment Court Program to provide and release the information listed below to _____ (Provider), as well as any future providers who have or will have a treating provider relationship with me in connection with the case number listed above. I also authorize the Provider to provide and release any documents relevant to or regarding the information listed below to the treatment court team as specified in this Release of Information and Consent Form:

_____ My personal identifying information includes but is not limited to, my name, age, date of birth, social security number, race, gender, marital status, education, employment status, income, address, phone number(s), and driver's license number;

_____ All protected medical information about me, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and under the rules and regulations thereunder, including all protected information from primary and secondary providers, health plans, health care clearing houses, emergency services, financial and administrative transactions, psychotherapy treatment, and business associates;

_____ My diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, and treatment prognosis. I understand the information disclosed by the Provider will be as limited as possible.

_____ All of my substance use disorder information about any controlled substances and/or alcohol;

_____ All of my medications, including my substance use disorder medications;

_____ All of my urinalysis lab test results related to my substance use disorder;

_____ Information about any illegal substance usage, alcohol, or substance abuse by me; and

_____ Information about my conditions of release or conditions of probation supervision by the Court (collectively referred to as "Sensitive Information").

I authorize the _____ (Program Name) Treatment Court and the identified team members to receive the information listed above from the Provider and to communicate and disclose this information to one another:

_____ Chief Judge

_____ Presiding Program Judge

Use Note: This Form is to be used by an individual who is in a Treatment Court or who is receiving treatment or services from a provider in connection with a case pending induction into a Treatment Court;

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_____ Alternate Program Judge	_____ Program Manager/Coordinator
_____ Program Director	_____ Assigned Treatment Representative(s)
_____ Chief Probation Officer	_____ Assigned Program Prosecuting Attorney(s)
_____ Chief Specialty Court Officer	_____ Assigned Program Defense Attorney(s)
_____ Assigned Probation Officer(s)	_____ Assigned Law Enforcement Officer(s)
_____ Assigned Surveillance Officer(s)	_____ Other (title): _____
_____ Assigned Compliance Officer(s)	_____ Other (title): _____
_____ Assigned Pre-Trial Officer(s)	_____ Other (title): _____
_____ Assigned Case Manager(s)	_____ Other (title): _____

_____ I agree and am required to be diagnosed, evaluated, and/or treated by the program's contracted Treatment Provider and I might be denied services if I refuse to consent to the disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes.

_____ I understand and agree that the purpose of the disclosures is to inform the Treatment Court Team listed above about my compliance with treatment including my attendance and progress in treatment to verify that I am complying with my conditions of release, conditions of probation, and/or any other order or judgment of the Court. I also understand that my alcohol and/or substance 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 and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts. 160 & 164.

_____ I understand that my review hearings are held in an open and public courtroom and that it is possible for someone observing the hearing to connect my identity with the fact that I am in treatment as a condition of participation in the treatment court. I specifically consent to this potential disclosure to third persons.

_____ I understand that my information may be released to the New Mexico Administrative Office of the Courts Therapeutic Justice Support Program for the management of the data system, consultation, court/staffing, and/or program evaluation, and collected anonymously for data and research.

_____ I further understand and agree that the Court may choose to invite judges or representatives of other courts and such other qualified visitors ("Visitors") to observe Court proceedings and/or meetings about my treatment to evaluate programs of the Court, conduct scientific research, management audits, and/or financial audits of the Court. I specifically consent to this potential disclosure of Sensitive Information (defined above) to any such Visitors.

_____ I understand the program may change the details or conditions of this release in the future, and I will be given a new Release of Information and Consent Form to review and sign if anything changes.

_____ I understand that I have a right to request and receive a list of the disclosures of my information made to any individual or agency described in this agreement.

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_____ I further understand and agree that this Release and Consent will remain in place until the Court enters a final disposition in my case. This Release and Consent is subject to revocation at any time after the Court enters a final disposition, except to the extent that the Court or Provider, which is going to make the disclosures, or the recipients who will be receiving the disclosures, has already taken action in reliance on it. I also understand that any disclosure concerning drug and alcohol abuse is subject to 42 CFR Part 2 and that the recipients of this information may only redisclose it in connection with their official duties, such as for the purpose of conducting scientific research, management audits, financial audits, or program evaluation.

_____ I understand that I have the right to revoke my consent at any time. I also understand if I refuse to consent to disclosure or attempt to revoke my consent before the expiration of this consent, that such action is grounds for immediate termination from the treatment court. I also understand if there has been a formal and effective termination or revocation of my release from confinement, probation or parole, or other proceeding under which I was mandated into treatment this consent will expire automatically.

_____ I have received a copy of this form.

_____ I acknowledge that I have been advised of my rights, have had the opportunity to review the content of this form, and consult with an attorney before signing, or have voluntarily waived the right to an attorney. I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this Consent voluntarily.

Date

Participant Signature

Date

Witness Signature

NOTICE TO RECIPIENTS:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

NOTICE TO PARTICIPANT: Violation of 42 CFR Part 2 is a reportable crime and as covered in HIPAA, if you believe your confidentiality or privacy rights have been violated you may report any suspected violations to the NM Administrative Office of the Courts, Therapeutic Justice Support Program by emailing aoc-te-grp@nmcourts.gov or by phone at (505) 827-4800 and/or to the U.S. Department of Health and Human Services Office for Civil Rights by submitting a complaint through the online portal <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>. For more information please contact the NM Administrative Office of the Courts, Therapeutic Justice Support Program.

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