IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
PROBLEM SOLVING COURT PARTICIPANT
CONSENT FOR RELEASE/DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ Case No.: _____, authorize:
(Name of Defendant)

☐ The Presiding Judge _____ and team members of the

_____ Program
(Name of Court)

☐ _____ and representatives of the Cook County Adult Probation Department

☐ _____ and representatives of the Cook County State's Attorney's Office

☐ _____ and representatives of the Cook County Public Defender's Office

☐ _____ and representatives of Substance Use Disorder Treatment Providers

☐ _____ and representatives of Treatment Alternatives for Safe Communities

☐ _____ and representatives of Presence Health System

☐ _____ and representatives of any Veterans Health Administration (VHA) hospital or treatment facility or other service provider I am referred to during my participation in the above named program

☐ _____ and representatives of the Cook County Sheriff, or any law enforcement team member

☐ _____ and representatives of the Chief Judge's Office and any other person permitted by the presiding judge to attend team staffing(s) for training and educational purposes.

☐ _____ as Problem Solving Court Coordinator

☐ _____ as _____

To communicate with and disclose to one another information concerning the following:

Any evaluation, diagnosis, prognosis, hospitalization, treatment, urinalysis result (including disclosure of test results in open court) or other information concerning my attendance, progress and compliance with treatment, substance use disorders, or otherwise related to my health or treatment. The purpose of the disclosure is to inform the court and other named person(s) listed above of my eligibility for treatment and my compliance and progress in treatment pursuant to the conditions of my court ordered participation in treatment.

I understand that my health and substance use disorder (SUD) records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts. 160 & 164, and that my mental health records are protected under the Illinois Mental Health and Developmental Disabilities Confidentiality Act (MHDDCA), 740 ILCS 110/1. 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 automatically when 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, or _____ .
(Specify other time)

I understand that I may request a specific list of exactly which records have been disclosed.

I understand that I might be denied services if I refuse to consent to a 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 a disclosure for other purposes. I recognize that my review hearings are held in an open and public courtroom and it is possible that an observer could connect my identity with the fact that I am in treatment as a condition of participation in a Cook County Problem Solving Court. I specifically consent to this potential disclosure to third persons.

I understand that if I refuse to consent to disclosure or attempt to revoke my consent prior to the expiration of this consent, that such action is grounds for immediate termination from the Cook County Problem Solving Court in which I am enrolled.

I acknowledge that I have 1) been provided a copy of this consent form, and 2) been advised of my rights, have received a copy of the advisement, and have had the benefit of legal counsel 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.

Dated: _____

_____
Signature of Problem Solving Court Participant

_____
Position

_____
Witness

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in substance use disorder or mental health treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal (42 CFR Part 2) and Illinois (740 ILCS 110/1) confidentiality rules/law. Those federal and state rules/law prohibit you from making any further disclosure of this information 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 or 740 ILCS 110/1. A general authorization for the release of medical and other information is NOT sufficient for this purpose. The federal and state rules also restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse or mental health patient.

You may report any violations of your privacy right to the Department of Health and Human Services. Information and procedures on reporting a violation may be found at www.hhs.gov. Written complaint may be submitted to: Centralized Case Management Operations U.S. Department of Health and Human Services 200 Independence Ave., S.W. Room 509F HHH Building Washington D.C., 20201. A complaint may be emailed to: ocrcomplaint@hhs.gov. You may also contact the Illinois Department of Human Services at 1-800-843-6154