OK AS TO FORM
RM 1-11-12

RLJ Restorative Justice Louisville, Inc.

CONSENT TO SHARE, RELEASE OR REQUEST INFORMATION

RE: _____ A/K/A: _____ _____
Participant's Name Birth Date

_____ _____ _____ _____
Address City State Zip Code

I, _____ authorize Restorative Justice Louisville, Inc. to____ disclose to or _____
(Name of Participant) (Check one)

request from _____
(Name of person or organization to disclose to or request from)

the following information:_____
(Nature of information, as limited as possible)

I am aware this record may contain psychiatric, drug, alcohol abuse, HIV infection, or sexually transmitted disease information. I understand this information may be redisclosed and thus no longer protected as confidential.

These items are not to be released unless specifically checked:

_____ Psychiatric or Mental Health _____ Alcohol or Drug Treatment Information

_____ AIDS/HIV Related Results _____ Sexually Transmitted Disease Information

The purpose of the disclosure authorized herein is to: _____
(Purpose of disclosure, be specific as possible)

_____

I understand my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse Records, 42 CFR, Part 2, and under certain circumstances, HIPPA Standards for Privacy of Health Information, 45 CFR, Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent in writing at any time by giving a signed copy of the revocation to the Restorative Justice Louisville, Inc. staff 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 or upon completion of the program, whichever is later, unless an earlier date is specified.

Earlier date requested: _____ _____ If yes, (state earlier date) _____
Yes No

DATE:_____ SIGNATURE:_____
(Participant or Authorized Party)

_____ _____
(Witness/Parent or Guardian) (Relationship if other than Participant)

TO THE RECIPENT OF THIS AUTHORIZATION: This is a limited disclosure for the purpose(s) stipulated above and so indicated by the person from whose records this information has been extracted. EACH DISCLOSURE WILL BE ACCOMPANIED BY THE FOLLOWING STATEMENT: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES. FEDERAL RULES 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 45 CFR, PART 160 AND 164. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS INSUFFICIENT FOR THIS PURPOSE. FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION OBTAINED HEREIN TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.