CONFIDENTIAL **SHEBOYGAN AREA VETERANS TREATMENT COURT**

VETERAN OR SERVICE MEMBER PARTICIPANT RELEASE OF CONFIDENTIAL INFORMATION

Case No._____

Name of Veterans Court Participant	Date of Birth	Social Security Number

Street Address	City	State	Zip Code

I. RECIPROCAL AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I hereby authorize the Sheboygan County Veterans Treatment Court Team, consisting of the Veterans Court Judge, the Veterans Court Coordinator, the Public Defender's Office, the District Attorney's Office, the Department of Corrections, the Veterans Administration, my other identified medical and/or behavioral health treatment providers, and my attorney, if any, to release my confidential medical and behavioral health care information pertinent to my participation in the Sheboygan Area Veterans Court Program to each other.

I understand that anonymous information regarding my participation in the Sheboygan Area Veterans Court Treatment Program may from time to time be forwarded to a Veterans Court Evaluator. If at any time my Veterans Court file is made available to the Veterans Court Evaluator, any identifying information obtained by the Veterans Court Evaluator will remain confidential with the Veterans Court Evaluator.

The purpose for the disclosure is to:

1. **Determine suitability for admittance to the Veterans Court Program, and**
2. **Monitor ongoing treatment during the Veterans Court obligation of the Veterans Court Participant.**

A requirement of participation in the Veterans Court Program is maintaining a validly executed Reciprocal Authorization for Disclosure of Confidential of Information at all times.

All information discussed during meetings of the Veterans Court Team will be confidential. No information discussed during Veterans Court Team meetings will be discussed with non-team members.

Date:

Veterans Court Participant Initials:

Witness Initials:

CONFIDENTIAL

Name of Veterans Court Participant:_____ Case No._____

From time to time, other people, such as treatment providers, screeners or other pre-authorized observers can observe a Veterans Court Team meeting with the understanding that the meetings are confidential. Anyone observing a Veterans Court Team meeting shall sign an acknowledgement of confidentiality.

I understand that my name and photograph may be released to area pharmacists following a determination of necessity by the Veterans Court Team.

I understand that I have a right to inspect and receive a copy of any written material to be disclosed, per HSS 92.05 and 92.06. I further understand that my alcohol and/or drug treatment records are protected under the federal law and regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and Chapter 48 and 51, Wis. Stats., and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical records are protected by federal law and regulations. I also understand that my records concerning mental health services I receive are protected by state law.

I also understand that this consent is required for my admission into the Veterans Court Program and that this consent shall remain in effect until my completion or termination from the Sheboygan Area Veterans Court Program. I understand that I may revoke this authorization at any time in writing, and that revocation of this authorization will result in termination from the Program. I understand that my records may be transmitted by facsimile or through other electronic means.

II. AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR BEHAVIORAL HEALTH TREATMENT INFORMATION

I hereby authorize and request that the Sheboygan Area Veterans Court Program Veterans Court Team release to, obtain from, and share any and all medical and/or behavioral health history and treatment information with the following providers:

Initial all that apply:

_____ Veterans Administration
_____ (Other)_____
_____ (Other)_____
_____ (Other)_____

Date:

Veterans Court Participant Initials:

Witness Initials:

CONFIDENTIAL

Name of Veterans Court Participant:_____ Case No._____

The information obtained pursuant to this release will remain confidential among the members of the Veterans Court Team and any treatment providers that may be involved with the Veterans Court Participant as a condition of the Sheboygan Area Veterans Court Program. This information may not be released to any other parties without my written consent. I understand that any admissions that I make to any Veterans Court Team member will not be used against me in any termination hearing or proceeding.

I UNDERSTAND THAT THIS MEDICAL AND/OR BEHAVIORAL HEALTH TREATMENT AUTHORIZATION FOR RELEASE OF INFORMATION SHALL REMAIN IN EFFECT DURING THE TERM OF MY PARTICIPATION IN THE SHEBOYGAN AREA VETERANS COURT PROGRAM.

I understand that I have a right to access my medical and/or behavioral health records information, including treatment records resulting from both hospitalization and outpatient care. Copies of any requested records may be obtained with reasonable notice and payment of copying costs through the institution's records department.

_____ _____

Veterans Court Participant Date:

Date:

Veterans Court Participant Initials:

Witness Initials:

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