Davidson County Residential Drug Court

Program Application

1406 County Hospital Road
Nashville, TN 37218

615-862-4230

Version 1.0 September 2022

DAVIDSON COUNTY RESIDENTIAL DRUG COURT (DC4)

READ CAREFULLY: Thank you for your interest in applying to be a participant in DC4. Each applicant must **completely** and **accurately** fill out this application form including the attached medical history form. Applicants must **thoroughly** read this application form, agree to be bound by all of its terms and conditions, and sign the form as requested in the application.

The applicant's referring entity must provide the additional documentation described in the "Application Process and Required Materials for Admission to DC4" section and sign the form as requested in the application.

I. Applicant's Demographic Information:

Full Legal Name: _____
(Last) (First) (Middle)

Date of Birth: _____(MM/DD/YYYY) Age: _____

Sex: Male ☐ Female ☐

Social Security No.: _____-____-_____

Are you a military veteran? Yes ☐ No ☐ Type of Discharge: _____
**attach copy of DD Form 214 Certificate of Release or Discharge from active duty, if available.

II. Referral Information:

Referral Name: _____

Referral Title (e.g., Defense Counsel, D.A., Recovery Court Administrator):

_____

III. Legal Information:

Originating Court: _____

Originating Court Judge: _____

Originating Court Phone: _____

Originating Court E-mail Address: _____

Attorney Name: _____ Phone No.: _____

_____
Criminal Charges Relevant to Referral

_____
County(ies) and Docket number(s) of criminal judgments relevant to referral to DC4

Date of last arrest: _____ (MM/DD/YYYY)

Other than these charges and sentences identified above, are there any other pending criminal charges or warrants against you (including: probation or community corrections violations) or are you subject to an outstanding sentence, in any jurisdiction? Yes ☐ No ☐

If Yes, on a separate sheet of paper, state the nature and jurisdiction of your pending unresolved charges or warrants or outstanding sentences.

IV. Description of Davidson Residential County Drug Court Program:

DC4 is a court-supervised residential recovery court program for non-violent felony offenders, who have a need for intensive substance abuse treatment and supervision. The primary purpose of the program is to provide court-supervised long-term residential services to individuals with substance use disorder, with follow-on services to assist offenders with re-entry into the community. The program is open to legally eligible offenders from across the State of Tennessee.

The DC4 Program is part of the drug court system overseen by the Tennessee Department of Mental Health and Substance Abuse Services. DC4 is presided over by Judge Jennifer Smith, a Criminal Court Judge from the 20th Judicial District in Nashville, Tennessee.

DC4 is post-plea. Participants are supervised by the Davidson County Community Corrections Program (DCCCP). Applicants are screened based on legal eligibility, criminal background, severity of addiction, medical, and other considerations. The duration of the application process will depend on numerous factors including the number of applicants, number of available beds, and completion of all required documents and screenings. When an applicant has been accepted, the referring court must enter Judgment placing the participant on community corrections or state probation conditioned upon DCCCP supervision, along with an order transferring jurisdiction to the DC4 Presiding Judge. A copy of the Judgment and order must be sent to DC4.

The DC4 Presiding Judge assumes jurisdiction over each participant while in the DC4 Program. Participants receive treatment, as indicated through clinical assessment, for approximately 24 months, which includes both residential (minimum 12 months) and aftercare (minimum 9 months) components. The actual length of treatment depends upon individual progress. Referring entities will receive periodic

updates on each participant while in the program and notification of successful completion. The DC4 Presiding Judge will make the final decision regarding graduation from the DC4 Program. When a participant successfully graduates from the DC4 Program, he or she is stepped down from community corrections to state probation for the remainder of their sentence. The individual may choose to remain in Davidson County or return to his or her home county. A referring recovery court may request that a resident participate in that court's aftercare program. In that instance, the resident will be discharged from DC4 at the conclusion of the residential component of the program and transferred back to the referring court. The DC4 staff will work with the resident and his or her referring court's staff to prepare an appropriate transition plan.

V. Eligibility Criteria for Admission to DC4:

To be eligible for admission to the DC4, the applicant must satisfy the following criteria:

1. The applicant must qualify for participation in a drug court treatment program under Tenn. Code Ann. § 16-22-101 et. seq. This means, among other things, that the applicant cannot be a violent offender or sex offender.

2. The applicant must not have any escape charges in their criminal history nor have more than two absconding violations of probation in their criminal history.

3. The applicant must be recommended to DC4 by a state trial court or court official.

4. Participation in the program is voluntary. The applicant must affirmatively express an interest in the DC4 Program and agree to follow all DC4 rules and policies.

5. The applicant must be a felony offender subject to one or more criminal judgments with sentences of three years or more.

6. The applicant must be eligible for probation under Tenn. Code Ann. § 40-35-303 or community corrections under Tenn. Code Ann. § 40-36-106.

7. The applicant must not have any pending or unresolved criminal charges in any jurisdiction, including jurisdictions outside of Tennessee, at the time of entry to the program.

8. The applicant must be assessed for a substance use disorder, and it must be determined that he or she meets the criteria for a substance use disorder.

9. The applicant's TN-RAS summary score must be in the High to Extremely High Range.

10. The applicant must not be diagnosed with any significant medical or psychiatric problems that DC4 staff, in its assessment, is not equipped to manage.

11. The applicant must be approved for participation in the DC4 program by the DC4 Program Director and DC4 Presiding Judge.

The admission of an applicant to DC4 is entirely discretionary with the DC4 Executive Director and the Presiding Judge. All applicants must be approved for final placement by the District Attorney General and sentencing Judge in the county of conviction.

VI. Application Process and Required Materials for Admission to DC4:

The following application materials must be submitted to DC4 Admissions Team via email: DC4Admissions@jisnashville.gov.

1. This application form filled out and signed by the applicant and a representative of the referring entity.

2. Medical history filled out and signed by the applicant. The applicant must include any current medications and the date and dosage of medications last taken by the applicant.

3. HIPAA Release signed by the applicant (included as the last page of this document).

4. Copy of the applicant's criminal history.

5. If the applicant is a military veteran, the applicants DD Form 214, certificate of release or discharge from active-duty information must also be included, if available.

NOTE: Ensure all signatures are completed or the application will not be accepted.

Upon receipt of the complete admission application described above, the DC4 Assessment Counselor will schedule a formal screening interview with applicants who meet the basic admission criteria. Screening interviews shall normally occur during business hours and shall include completion of the Addiction Severity Index (ASI) and Tennessee Risk Assessment System (TN-RAS).

Note: A referring recovery court may furnish a completed TN-RAS, a completed ASI, and the applicant's criminal background. Providing this information at the outset of the application process may help speed the admission decision process.

When an applicant has been formally accepted for admission to DC4, the originating court must enter an appropriate Order transferring jurisdiction to the DC4 Presiding Judge. A copy of that Order and the participant's underlying criminal Judgment must be sent to DC4.

VII. Participation in the DC4 Program:

DC4 utilizes evidence-based treatment practices. The program is operated as a modified therapeutic community combined with gender specific and trauma specific treatment with a foundation of the 12 steps of recovery. It is important that all residents make progress in their recovery and participate in the community in a positive way.

In its discretion, DC4 may discharge any resident from the program for a variety of reasons, including, but not limited to the following:

1. The resident is diagnosed with a medical, psychiatric, or psychological condition that the DC4 staff is not equipped to manage.

2. The resident is unwilling or unable to fully participate in the DC4 program, including the clinical activities and community service.

3. In the clinical judgment of the DC4 treatment team, the resident is not making satisfactory progress in his or her treatment or recovery program or is not open to treatment at DC4.

4. In the clinical judgment of the DC4 treatment team, the resident is a negative influence in the DC4 community which potentially undermines treatment or recovery of other residents.

5. The resident commits a Level 1 rule violation or continues to commit rule violations without improving his or her behavior.

If for any reason a resident is terminated from the DC4 program, his or her case will be transferred back to the referring court for further disposition.

VIII. Applicant's Agreement: **(signature required below)**

I, _____ [print your name], agree to the following:

1. Agreement to be bound by DC4 Rules and Policies:
   I understand and agree that if I am admitted to DC4, I will obey all DC4 rules and policies. **I understand that my failure to follow said rules and policies can bring about sanctions, including incarceration and/or my immediate expulsion from the program.**

2. Agreement to live at the DC4 facility:
   If I am admitted to DC4, I agree to live at the DC4 facility as recommended by the DC4 treatment team.

3. Acknowledgement of Limited Medical Care:
   I understand and acknowledge that DC4 is equipped to manage only basic medical and psychiatric needs and costs for such services, are limited to the following: (1) on-site part-time nursing; (2) on-site part-time psychiatric nurse practitioner; (3) recovery-safe medications prescribed by DC4 medical providers; and (4) limited dental care.

   I understand that I will be held financially responsible for any medical and dental care (including ambulance and emergency room treatment) that DC4 is not equipped to manage or that is beyond the scope of the practices provided by on-site nursing.

4. Communication:
   I understand that communication with anyone outside of the DC4 campus is a privilege. The following is an outline of the community policy:

- Mail: Incoming and outgoing mail is subject to being searched.

- Phone: On the day of your intake at DC4, you will be allowed an initial phone call. After the initial phone call, unless an emergency arises, residents are not allowed to communicate with anyone outside of the DC4 facility by phone for at least the first 30 days. After 30 days when telephone calls are permitted, they are usually limited to one call weekly. Additional calls may be permitted as an incentive for progress in the program.

    - Family visits: After a minimum time in the program, as an incentive for progress in the program, DC4 residents will be allowed family visits.
        1. Visitation is determined by recommendation of the counselor, and a request is made by the counselor to the DC4 Presiding Judge for approval.
        2. Frequency of visitation and planning of visitation are coordinated by the counselor with the resident.
        3. Visits may be facilitated in person or remotely.

- Passes: Residents will only be allowed passes away from the DC4 campus for recovery-related purposes, approved community service projects, and/or as approved by the DC4 staff and Presiding Judge.

NOTE: Phone calls, family visits, and passes are not guaranteed. Phone calls are approved by staff. Family visits and passes must be approved by the DC4 Presiding Judge.

5. Acknowledgement of Personal Property:
I understand that I will be limited to the personal property that I may have at DC4. I understand that DC4 will not be responsible for any lost or missing personal property.

6. Acknowledgement of Searches and Seizures:
I understand, and hereby give my consent, that while I am at DC4, my belongings and my personal area may be searched by staff at any time without notice. I also understand and agree that any prohibited items, or any other items deemed by staff to be inappropriate that are in my possession, may be confiscated by DC4 staff.

7. Acknowledgement of Drug Testing:
I understand and agree that while I am at DC4, I may be drug tested at any time without notice. I also understand and agree that a positive drug test may result in sanctions or termination from the program.

8. Acknowledgement of Absconding:
I understand that if I ever leave the DC4 campus unaccompanied by a DC4 staff member without a proper written authorization, I may be prosecuted for felony escape pursuant to Tenn. Code Ann. § 39-16-605(a), (c)(1)(B), in addition to violation of probation or community corrections. There will be no exceptions to this rule.

9. Acknowledge of Agreement Regarding My Behavior:

I, _____ agree:

- To accept and abide by the directives of the DC4 staff and to follow all DC4's rules and policies;
- To make full and truthful reports to any staff member upon request;
- Not to possess or use alcohol, drugs, or any prohibited items;
- Not to engage in any physical altercation or verbal abuse with any member of the DC4 community – this includes all staff members and all residents;
- Not to use foul language;
- To actively engage in my recovery program and in community service work under staff supervision; and
- To treat all members of the DC4 community (staff and residents) with respect.

10. Possible Consequences for Violating this Agreement or the DC4 Rules**:**
I fully understand that I am transferring the supervision of my sentence to the Presiding Judge overseeing DC4. Should I violate any of the terms and conditions of this agreement or the DC4 rules and policies, I understand that I may be subject to:

    1. The imposition of a jail sanction of up to twenty-one (21) days without a hearing;
    2. Referral back to the jurisdiction of my referring entity, and that Judge shall have the right to rule upon said violation and impose any sentence that is deemed appropriate; and/or
    3. Termination from the DC4 program.

I understand that if I am terminated from the DC4 Program, for any reason, then:

1. If I am on furlough, my furlough could be terminated, and I could be returned to the appropriate penal institution without the benefit of a hearing.
2. If I am on community corrections, after a hearing, my community corrections could be revoked, and the court could enhance my sentence.
3. If I am on probation, after my hearing, my probation could be revoked.

Signed: _____ [Applicant] **SIGNATURE NEEDED HERE**

IX. SIGNATURE PAGE

In the space given below, please briefly write the reason you want to be admitted to Davidson County Drug Court:

_____
_____
_____
_____
_____
_____

Have you read this entire form, and do you understand it? (**Write yes or no**)

Have you had the opportunity to discuss this application form and the DC4 program with your attorney and with your referring entity? (**Write yes or no**)

Referring entity (this must be completed):

DC4 Applicant Signature: _____

Date: _____

Referring entity (this must be completed):

By (Name): _____

Title: _____

Date: _____

Note: it is the responsibility of the referring court to arrange transportation for the participant to the Davidson County Sheriff's Office and, if a participant is expelled from the DC4 program, from The Davidson County Sheriff's Office to their home county.

I, _____ (print your name), agree to the following:

1. I have read and I fully understand all provisions of this application form.
2. I have had the opportunity to review this application form with my attorney.
3. I have read and I fully understand all agreements listed above.
4. I understand the possible consequences for violating this agreement or the DC4 rules.

Applicant Signature: _____ Date: _____

Provisions for Referring entity:

1. Recommendations for Admission to DC4: By signing this application form, the applicant's referring entity is recommending the applicant's admission to the DC4.

2. Certification of Applicant's Eligibility: By signing this application form, the applicant's referring entity is certifying that, to the best of the entity's knowledge, the applicant satisfies all eligibility requirements for participating in the DC4 program as set forth in the above eligibility section.

3. Transportation: When an applicant is admitted to DC4, the referring jurisdiction is responsible for transporting the resident to the Davidson County Sheriff's Department. Upon arrival, the resident will be set on the Davidson County Criminal Court docket for acceptance by the Drug Court Judge.

4. Prescription Medications: If a new resident is taking prescribed medications, they should bring at least a three-week supply and should bring any written prescriptions for refills or renewals.

5. No Luggage: A new resident's personal belongings should be contained in a plastic bag. DC4 does not have space to store luggage.

6. Cash: Residents may not possess more than $25.00 unsecured by staff. Families may send additional money, but any amount over $25.00 will be secured by DC4 staff.

7. Clothing: A resident's term at DC4 will cover all seasons of the year. However, space for storing clothes is limited. If a resident cannot afford clothing, DC4 will provide necessary clothing items.

8. Hygiene: New residents are encouraged to bring hygiene items that are sealed, unopened and do not contain any alcohol. If a resident cannot afford these items, DC4 will provide them, or items may be mailed to DC4 Counselors. The mailing address is 1604 County Hospital Road, Nashville, TN, 37208. NOTE: All items will be searched upon arrival.

9. Termination from the Program: If a resident is terminated from the DC4 program, DC4 will promptly notify the referring entity. The case will be transferred back to the referring entity. The referring entity will be responsible for transporting the resident back to that court's jurisdiction. The referring entity will have **a maximum of 7 calendar days** to have the resident picked up from the Davidson County Sheriff's Office.

10. Completion of the Program: When a participant successfully completes the DC4 Program, including the aftercare component, he or she is stepped down from community corrections to state probation for the remainder of their sentence. The individual may choose to remain in Davidson County or return to his or her home county. A referring recovery court may request that the participant participate in the referring entity's aftercare program. In that instance, the participant will be discharged from DC4 and transferred back to the referring court. The DC4 staff will work with the resident and his or her referring entity's staff to prepare an appropriate transition plan.

Davidson County Residential Drug Court

PLEASE FILL OUT ALL FORMS THOROUGHLY

MEDICAL HISTORY FORM
Applicant Information

Full Name: _____
Last First Middle Initial

Date of Birth: _____ Today's Date: _____

SOCIAL HISTORY
Marital Status

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Other

Tobacco Use

Cigarettes/cigars/pipes:
☐ Never ☐ Used in the past Quit Date: _____
☐ Current _____ (no.) of packs/day for _____ years

Chewing tobacco
☐ Never ☐ Used in the past Quit Date: _____
☐ Currently use _____ (no.) of packs/day for _____ years

PAST MEDICAL HISTORY

Please select if you have or have had any of the following:

☐ Environmental Allergies ☐ Depression ☐ Heart Attack
☐ Anemia (low blood) ☐ Diabetes ☐ Nerve or Muscle Disease
☐ Anxiety ☐ Emphysema ☐ Glaucoma
☐ Asthma ☐ Seizures ☐ GERD (heartburn/reflux)
☐ Sickle Cell Anemia ☐ Cancer ☐ Heart Murmur
☐ Stroke ☐ Cataracts ☐ HIV/AIDS
☐ Congestive Heart Failure ☐ High Cholesterol ☐ Thyroid Disease
☐ Clotting Disorder ☐ High Blood Pressure ☐ Tuberculosis
☐ COPD ☐ Kidney disease ☐ Ulcers
☐ Meningitis ☐ Pregnancy or suspected pregnancy

Other: _____

PAST SURGICAL HISTORY

Please select if you have or have had any of the following:

☐ Appendectomy
☐ Brain Surgery
☐ Tonsils/Adenoids
☐ Hernia Repair
☐ Valve Surgery (heart valve)
☐ Vascular (vein/artery)
☐ Colon Surgery
☐ Joint Replacement
☐ Cardiac Artery Surgery
☐ Pacemaker/defibrillator
☐ Eye Surgery
☐ Sinus Surgery
☐ Fracture Surgery
☐ Angioplasty/Stent
☐ Ear Surgery
☐ Small Intestine Surgery
☐ Spine Surgery
☐ Gallbladder Removal

Other: _____

FAMILY MEDICAL HISTORY

Father:

Alive: ☐ Yes ☐ No

Father's Age: _____ Substance Abuse: ☐ Yes ☐ No

Substance Abuse Issues:
(If yes, please describe): _____

Father's general health is: ☐ Good ☐ Fair ☐ Poor
Reason for father's poor health: _____

Cause of death: _____

Mother:

Alive: ☐ Yes ☐ No

Mother's Age: ____ Substance Abuse: ☐ Yes ☐ No

Substance Abuse Issues:
(If yes, please describe): _____

Mother's general health is: ☐ Good ☐ Fair ☐ Poor
Reason for mother's poor health: _____

Cause of death: _____

Siblings:

Number of brothers: ____ Health Problems: _____

Number of sisters: ____ Health Problems: _____

FAMILIAL DISEASES

Have you or any of your blood relatives had any of the following (include grandparents, aunts, and uncles), but exclude cousins, relatives by marriage and half-relatives. Check those to which the answer is yes (leave other blank).

☐ Heart attack under age 50
☐ Strokes under age 50
☐ High blood pressure
☐ Elevated cholesterol
☐ Diabetes
☐ Asthma or hay fever
☐ Congenital Heart Disease (existing at birth/not hereditary)
☐ Heart Surgery
☐ Glaucoma
☐ Obesity (20 or more pounds overweight)
☐ Leukemia or Cancer under age 60

Comments: _____

MEDICATIONS

Please complete accurately

	MEDICATION NAME	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			

Comments:

MEDICAL ALLERGIES

1.
2.
3.
4.
5.
6.

Comments:

REVIEW OF SYMPTOMS

REVIEW OF SYMPTOMS: Select the items in each category that <u>have</u> or <u>have not</u> caused you problems or discomfort.

<u>General</u>:

Recent weight change: ☐ Yes ☐ No
Fever/chills: ☐ Yes ☐ No
Night sweats:☐ Yes ☐ No
Fatigue: ☐ Yes ☐ No
Malaise/feeling ill: ☐ Yes ☐ No
Vascular (vein/artery): ☐ Yes ☐ No

<u>Genitourinary</u>:

Frequent/urgent urination: ☐ Yes ☐ No
Burning/painful urination: ☐ Yes ☐ No
Blood in urine: ☐ Yes ☐ No
Difficulty with urination: ☐ Yes ☐ No

<u>Gastrointestinal</u>:

Loss of Appetite: ☐ Yes ☐ No
Nausea or vomiting: ☐ Yes ☐ No
Heartburn/reflux: ☐ Yes ☐ No
Abdominal pain: ☐ Yes ☐ No
Diarrhea: ☐ Yes ☐ No
Constipation: ☐Yes ☐ No
Rectal bleeding/blood in stool: ☐ Yes ☐ No

<u>Musculoskeletal</u>:

Joint stiffness: ☐ Yes ☐ No
Joint pain: ☐ Yes ☐ No
Joint swelling: ☐ Yes ☐ No
Muscle weakness: ☐ Yes ☐ No
Muscle pain/injury: ☐ Yes ☐ No
Limb pain/injury: ☐ Yes ☐ No
Back pain/injury: ☐ Yes ☐ No
Neck pain/injury: ☐ Yes ☐ No
Difficulty walking: ☐ Yes ☐ No

<u>Allergic/Immunologic</u>:

Sneezing/runny nose: ☐ Yes ☐ No
Itchy/irritated eyes: ☐ Yes ☐ No
Nasal/sinus congestion: ☐ Yes ☐ No
Frequent colds/illness: ☐ Yes ☐ No
Recurrent pneumonia: ☐ Yes ☐ No
Recurrent sinus infections: ☐ Yes ☐ No

<u>Cardiovascular</u>:

Chest pain: ☐Yes ☐ No
Palpitation/irregular heartbeat:☐ Yes ☐ No
Rapid heartbeat: ☐ Yes ☐ No
Shortness of breath: ☐ Yes ☐ No
Swelling of feet/ankles/hands: ☐ Yes ☐ No

<u>Ear/Nose/Throat/Mouth</u>:

Hearing Loss or ringing: ☐ Yes ☐ No
Earaches or drainage: ☐ Yes ☐ No
Sinus problems: ☐ Yes ☐ No
Nose bleeds: ☐ Yes ☐ No
Sinus/face pain: ☐ Yes ☐ No

<u>Psychiatric</u>:

Sadness/Grief: ☐ Yes ☐ No
Depression: ☐ Yes ☐ No
Panic/Anxiety: ☐ Yes ☐ No
Stress: ☐ Yes ☐ No
Hallucinations: ☐ Yes ☐ No
Sleep problems: ☐ Yes ☐ No
Suicidal thoughts: ☐ Yes ☐ No

Neurological:

Headaches: ☐ Yes ☐ No
Concussion: ☐ Yes ☐ No
Lightheaded/dizzy: ☐ Yes ☐ No
Fainting/collapse: ☐ Yes ☐ No
Seizures: ☐ Yes ☐ No
Numbness/tingling: ☐ Yes ☐ No
Weakness: ☐ Yes ☐ No
Tremors: ☐ Yes ☐ No
Paralysis: ☐ Yes ☐ No
Head injury: ☐ Yes ☐ No

Integumentary:

Rash or itching: ☐ Yes ☐ No
Skin infection: ☐ Yes ☐ No

Respiratory:

Coughs: ☐ Yes ☐ No
Cough/spitting blood: ☐ Yes ☐ No
Shortness of breath: ☐ Yes ☐ No
Wheezing: ☐ Yes ☐ No

Eyes:

Eye pain: ☐ Yes ☐ No
Eye redness: ☐ Yes ☐ No
Vision changes: ☐ Yes ☐ No
Blurred/double vision: ☐ Yes ☐ No

Applicant Name: _____

Applicant Signature: _____

Date of Birth: _____

Today's Date: _____

Thank you for your interest in the DC4 program. Please review this application thoroughly for accuracy and completion of all fields before submission. Incomplete applications will take longer to process.

--DC4 Staff

DAVIDSON COUNTY RESIDENTIAL DRUG COURT

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME_____ **DOB**_____

I hereby authorize the release of the following specific information:

1. Summary of previous alcohol, drug, or mental health treatment or counseling record.
2. Psychological test reports
3. Psychiatric evaluation reports
4. Social history, including family, education, employment, arrest/legal and substance use history
5. Medical history, examination, lab tests, and treatment reports
6. Periodic and summary reports of current treatment progress, including attendance, participation, and drug screen results
7. Verification of admission/discharge
8. Medication history; information would include medications from health care providers involved in your care.
9. Other (specify) _____

FROM / TO:
Davidson Co. Drug Court (DC4)

FROM / TO:
NAME: _____
AGENCY: _____
ADDRESS: _____
_____
PHONE: _____ FAX: _____

I understand that this information will be used for the following purposes:

1. To develop a diagnosis, treatment and/or rehabilitation plan.
2. To coordinate medical, psychological, and social services.
3. To determine present and future eligibility for treatment or counseling.
4. To advise family and/or referring agency/party of the treatment process.
5. To fulfill court and legal requirements.

.

I understand that this information may be released in the following forms:

1. Verbal
2. Written
3. Fax
4. Scan/Email
5. Other (specify): _____

I understand my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.R.F. Pt. 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.R.F. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except that action has been taken in reliance on it and that in any event, this consent expires after 90 days after **termination or completion of the program**.

I understand that the Davidson County Drug Court Program does not condition my treatment on whether I sign a consent form, but in certain circumstances, I may be denied treatment if I do not sign a consent form because of treatment and my participation in the program would be impracticable. I also acknowledge that upon request, a copy of this release will be provided.

SIGNATURE OF PARTICIPANT:_____ DATE:_____

STAFF WITNESS: _____ DATE: _____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a client 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 individual whose information is being disclosed 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, except as provided at §§ 2.12(c)(5) and 2.65.*