

**NOTICE TO CLIENT REGARDING**

**CONFIDENTIALITY OF ALCOHOL, TOBACCO AND OTHER DRUG**

**ABUSE RECORDS**

The confidentiality of your identity and records as a substance abuse program client is protected by the program’s policies and by Federal law (see 42 C.S.C. 290dd-3 and 290ee-3 and 42 C.F.R. Part 2). Generally, program personnel may not acknowledge to outsiders that you are a client, or disclose your condition or other personal information, without your written consent or a court order.

**THERE ARE EXCEPTIONS**. All medical and mental health personnel will have access to your records as necessary to run the program and the agency. Others who participate in the program will meet you and know you are in treatment. Agencies and organizations which provide services to the agency, regulates the agency r program, or pay for the program or agency services may have access, with their written agreement to protect confidentiality. In medical emergencies, other medical personnel or the Food and Drug Administration may receive your records of information as necessary to respond to the emergency.

Also, certain disclosures are required by law. Suspected abuse of children or incompetent or disabled persons must be reported under State and Federal law. Certain vital statistics or communicable disease must be reported. Law enforcement agencies or others may be notified if you commit a crime on program premises or against program personnel. These reports may reveal information about your presence or status in the Substance Abuse Program.

As a part of the admission process, you will be asked to sign written consents to release your records to others, i.e. Probation/Parole Officers, selected family members, your physician, county mental health, 12-step Sponsor and other treatment providers who have an important role in your treatment.

Violation of the Federal regulations is a crime, and may be reported to appropriate authorities in accordance with the regulations. **Protecting your confidentiality is a big priority for us. Any Concerns you have in that regard should be discussed with your counselor or the program administrator.**

By signing below, I acknowledge that I have read and understand this information:

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(Date) (Signature of Defendant/Patient/Client)

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(Staff Witness) (Signature of Parent, Guardian, or Authorized Representative if Required)