Community Treatment Services
Authorization for Release of Information

Client Name:	Phone Number:
Register Number:	Date of Birth:

I authorize Transitional Care Management, LLP to release information to:

Federal Bureau of Prisons	Client Initials

and the following Agency:

United States Probation Office / Court Services and Offender Supervision Agency	Client Initials

Information includes the following clinical documentation: Treatment Summary, Referral Form, Substance Use Assessment, Mental Health Assessment, Crisis Intervention Report, Medication Monitoring Reports, Psychiatric Evaluation, Sex Offender Evaluation, Treatment Plans, Monthly Progress Reports, Termination Report, Treatment Services and Accountability Logs, Behavior Notification Forms, and other supplementary clinical documentation.

The purpose of the disclosure is to inform the person(s) listed above of my attendance, progress, and continuation of mental health, substance use disorder, medication-assisted treatment, and/or sex offender treatment.

Initial the following statements to indicate understanding:

_____ I understand this authorization is voluntary and that I may refuse to sign this authorization.

_____ I understand that my program treatment records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164. 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.

_____ I understand that this authorization will expire one year from the treatment authorization end date on:

_____.

_____ I understand that I may revoke this authorization at any time upon written request to: Reentry Services Division (Attn: CTS), 320 First St NW, Washington, DC 20534.

I have read the above, or it was read to me, and I authorize the disclosure of Protected Health Information as stated.

Client Signature: **Client gave verbal consent through telehealth**	Today's Date:
Contract Staff Witness Signature:	Contract Staff Witness Printed Name: **Lauren Herraiz**

cc: Community Treatment Services Office