

CHEROKEE COUNTY TREATMENT ACCOUNTABILITY COURT

**WAIVER AND CONSENT FOR THE RELEASE AND
COMMUNICATION OF CONFIDENTIAL INFORMATION**

I, _____, Social Security Number, _____ - _____ - _____,
Date of Birth, _____, Case Number, _____,
hereby consent to any and all communication including the exchange of confidential treatment records between the Cherokee County Treatment Accountability Court (TAC) and treatment providers, probation, the prosecutor's office, drug testing lab and other appropriate agencies regarding any and all information requested pertaining to me, to include but not be limited to information obtained through GCIC and/or NCIC record checks, and information concerning mental health, substance use, drug testing, diagnosis and treatment.

I understand that my attorney may take part in such communications.

I further authorize any prison, county jail or city jail in which I have been confined to release to the Cherokee County TAC all information in my records concerning tests for HIV(AIDs), Tuberculosis and Hepatitis.

The above information will be used by the Cherokee County Treatment Accountability Court for the following purposes:

- (a) to coordinate treatment services;
- (b) to provide referral information; and
- (c) to monitor compliance with a treatment program, including informing the Court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress and completion of treatment.

I understand that the Cherokee County TAC operates by a team philosophy. I further understand and authorize members of the Court, treatment providers, probation, the Cherokee County Adult Detention Center, the prosecutor's office and my defense attorney to routinely discuss my case, my progress and other information regarding my treatment and/or case.

This consent will remain in effect not to exceed five (5) years from the date of execution of my consent. I further understand that I can withdraw this consent, in writing, at any time prior to the expiration, but any information released prior to the withdrawal of consent remains authorized.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol, drug, and/or behavioral health treatment records, and the recipients of this information may disclose it only in connection with their official duties. This release is intended to comply with all laws of the State of Georgia and all provisions of HIPPA (45 C.F.R. Parts 160 & 164).

Signature of Defendant

Date

Witness

Date