

**MALHEUR COUNTY S.A.F.E. COURT
AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

By signing this form, you are authorizing the release of information between and among those identified for the purpose of planning and coordinating services for your treatment.

I authorize the following Malheur County S.A.F.E. Court Treatment Team members to share information regarding my treatment for drug and/or alcohol abuse:

Training & Employment Consortium Department of Human Services Rader, Stoddard & Perez S.A.F.E. Court Judges Lifeways Malheur County Juvenile Department	Malheur County Community Corrections Malheur County District Attorney S.A.F.E. Court Coordinator UNIO Dr. Lawrence Stoune Malheur County Correctional Facility (jail)
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**Polygrapher contracting for services
with Community Corrections**

and to release to and exchange with other agencies in order to assist me in receiving appropriate services in the community as listed here:

Type of Information/Records:

- | | |
|---|--|
| <input type="checkbox"/> Presence in program & services provided | <input type="checkbox"/> Educational records |
| <input type="checkbox"/> Family History | <input type="checkbox"/> Work/Unemployment |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Service Plan |
| <input type="checkbox"/> Medical/Health Services (<i>includes diagnosis, treatment & prognosis</i>) | <input type="checkbox"/> Financial Records |
| | <input type="checkbox"/> Polygraphy Results |
| | <input type="checkbox"/> Other _____ |

Please put your initials by the two additional records listed below if you agree to the release and exchange.

_____ Records of Mental Health/Psychiatric Treatment (*includes diagnosis, treatment and prognosis*)

_____ Records of Alcohol/Drug Treatment (*includes diagnosis, treatment and prognosis*)

This authorization shall remain in force as long as I am a participant in the Malheur County SAFE Court program and for a period not to exceed three years from the date that I leave the program. I can cancel this authorization at any time, but the cancellation will not affect any information that was already released before the cancellation. I understand that information about my family is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Authorizing Signature or Mark

Date

Witness Signature

Date

To those receiving information under this authorization: *This information disclosed to you is protected by state and federal law. You are¹ not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.*

_____ This is a true
copy of the original authorization document .Full signature of agency staff person making copies