NIAGARA COUNTY
PROBATION DEPARTMENT

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ANGELA BEIGHTOL
Supervisor

CONSENT FOR RELEASE OF INFORMATION

Extent or nature of information to be disclosed: **Treatment (Mental Health, Drug, Alcohol, Medical, Sex Offender Counseling), Diagnosis, Compliance, Participation, Recommendations, Treatment Goals, Medications**, **Domestic Violence**

Purpose or need for the disclosure: **Probation Supervision, Pre-Sentence Investigation, Pre-Dispositional Report, PINS Petition, PINS Diversion, JD Petition, Restore to Calendar Petition, Custody and Adoptions.**

Between: Niagara County Probation Department

And: _____
(Name or title of person or organization receiving or disclosing information)
Address: _____

I understand that my records are protected under Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 & 164; and that disclosure of this information to a party other than the one designated cannot be disclosed without my written consent unless otherwise provided for in the regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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, and that in any event this consent expires automatically as follows:

Specification of the date, event, or condition upon which this consent expires: One year from date below.

_____ _____
Client Name DOB

☐ By checking this box I confirm the validity of the information contained in this form.