



ASHLAND COUNTY WELLNESS & RECOVERY COURT

Reciprocal Authorization for Disclosure of Confidential Information

Name of Court Participant

Date of Birth

Social Security Number

Street Address

City

State

Zip Code

- 1) I hereby authorize the Wellness & Recovery Court (WRC) Team, including but not limited to the Circuit Court Judge, District Attorney, Defense Attorney, Department of Corrections, AODA Counselors, Human Services, Wellness & Recovery Court Coordinator, Program Evaluator, and law enforcement representatives to secure any information pertinent my program participation (including, but not limited to: diagnosis, therapy progress, alcohol and other drug use, referral and recommendation).
- 2) The purpose of, and need for, this disclosure is to inform the court and all other named parties of my eligibility and/or acceptability for substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the WRC program's monitoring criteria. This information may be released through verbal, written or electronic communication.
- 3) All information discussed during meetings of the Team will be confidential. No information discussed during Team meetings will be discussed with non-team members with the exception of the participant's Community Corrections Agent.
- 4) I understand that incentives may be granted by the Judge for complying with Wellness & Recovery Court Program requirements. I understand that sanctions and therapeutic treatment responses may be imposed by the Judge for failing to comply with program requirements.
- 5) From time to time, other people, such as treatment providers, screeners or observers interested in beginning a Wellness & Recovery Court can observe a Team meeting with the understanding that the meetings are confidential. Anyone observing a Team meeting shall sign an acknowledgement of confidentiality.
- 6) I understand that my name and photograph may be released to area pharmacists and emergency rooms.

- 7) I understand that I have a right to inspect and receive a copy of any written material to be disclosed, (per HFS 92.03 and 92.06 and Section 51.30, WI Stats., HFS 92.03-92.06 Wis. Ad. Code). I further understand that my records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2 and Chapter 51, Wis. Stats.
- 8) I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.
- 9) I understand that this consent is required for my admission into the Wellness & Recovery Court and that this Consent shall remain in effect until my completion or termination from the program.

Your rights with respect to this authorization

Right to inspect or copy the health information to be used or disclosed. I understand that I have a right to inspect or copy the health information to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting: Department of Corrections, 715-682-7246

Right to receive copy of this authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a copy of the signed form.

Right to refuse to sign this authorization. I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) listed above who I am authorizing to receive or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **I also understand that refusal to sign this form makes me ineligible for participation in the Ashland Wellness & Recovery Court.**

Right to cancel this authorization. I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not apply to information already released in response to this authorization. **I also understand that withdrawal of this authorization makes me ineligible for continued participation in the Ashland Wellness & Recovery Court.**

Wellness & Recovery Court Participant

Witness

Date

Date



ASHLAND COUNTY WELLNESS & RECOVERY COURT

Medical Treatment Authorization for Release of Information

I hereby authorize and request that the Ashland County Wellness & Recovery Court (WRC) Team release to, obtain from, and share all medical history and treatment information with the following health care providers:

<p>Name of Person's whose record will be released: _____</p> <p>Address: _____</p> <p>_____</p> <p>City, State, Zip Code: _____</p> <p>ID Number (if any): _____ Date of Birth: _____</p> <p>Information May Be Released To and/or From:</p> <p>Organization/Individual: _____</p> <p>Address: _____</p> <p>_____</p> <p>City, State, Zip code: _____</p>

The information obtained pursuant to this release will remain confidential among the members of the Team and any treatment providers that may be involved with the participant as a condition of the WRC Program. This information may not be released to any other parties without my written consent. **I understand that this medical treatment authorization for release of information shall remain in effect during the term of my participation in the WRC Program for a period up to twenty-four-months from the date of signature on the release, subject to any twelve-month extensions authorized by me.**

<p>Information to be released: (Check all that apply)</p> <ul style="list-style-type: none"><input type="checkbox"/> Medical History<input type="checkbox"/> Discharge Summary<input type="checkbox"/> Voc Eval Report<input type="checkbox"/> Medications<input type="checkbox"/> Diagnosis/Client History<input type="checkbox"/> Progress notes<input type="checkbox"/> Treatment/Care Plan <p>In Compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: (Check all the apply)</p> <ul style="list-style-type: none"><input type="checkbox"/> Mental Health<input type="checkbox"/> HIV<input type="checkbox"/> Developmental Disabilities<input type="checkbox"/> Sexually Transmitted Disease<input type="checkbox"/> Alcoholism<input type="checkbox"/> Drug Abuse<input type="checkbox"/> Other (Specify)
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Right to inspect or copy the health information to be used or disclosed. I understand that I have a right to inspect or copy the health information to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting: Department of Corrections, 715-682-7246

Right to receive copy of this authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a copy of the signed form.

Right to refuse to sign this authorization. I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) listed above who I am authorizing to receive or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I also understand that refusal to sign this form makes me ineligible for participation in the Ashland County Wellness & Recovery Court Program.

Right to cancel this authorization. I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not apply to information already released in response to this authorization. I also understand that withdrawal of this authorization makes me ineligible for continued participation in the Ashland County Wellness & Recovery Court Program.

Wellness & Recovery Court Participant

Witness

Date

Date



ASHLAND COUNTY WELLNESS & RECOVERY COURT

Participant Contract

I, _____, with a birth date of _____, and an address of _____ understand the governing case pertaining to this contract to be the following:

Case Number: _____

Referring violation or offense _____

Conviction/Status: _____ Supervision Status: _____

I understand that by entering into this Wellness & Recovery Court (WRC) Contract, the following terms apply:

- 1) I understand that the validity of this contract is conditioned upon my eligibility for this special treatment court. If at any time after the execution of this agreement and in any phase of WRC that I am ineligible to participate in the program, the Wellness & Recovery Court team may terminate me from the program.
- 2) I understand that if I enter this program and fail to complete it, I may be barred from future participation.
- 3) I understand that participation in the program involves a minimum time commitment of twelve months.
- 4) I understand that during the entire course of the program, I will be required to attend court sessions, treatment sessions, submit to random drug testing, remain sober, and law-abiding. I agree to abide by the rules and regulations imposed by the Wellness & Recovery Court Team. I understand that if I do not abide by these rules and regulations, I may be sanctioned or terminated from the program.
- 5) I understand that sanctions may include, but not limited to, time in custody, increased treatment sessions, increased alcohol and other drug testing and community service.
- 6) I agree to cooperate in an alcohol and other drug assessment for planning an individualized treatment program adequate to my needs. I understand that my treatment plan may be modified by the treatment provider or the Wellness & Recovery Court Team as circumstances arise, and I agree to comply with the requirements of any such modifications.
- 7) I understand that I am able to participate in medication-assisted treatment (MAT) as prescribed and monitored by a physician without violating the WRC participant contract. I will notify all medical personnel with whom I have contact of my involvement in Wellness & Recovery Court and will inform Wellness & Recovery Court staff immediately of any medical contacts and any medications prescribed to me.

- 8) I understand that I will be required to pay for some or all of the cost of my drug/alcohol therapy, and I will complete a financial declaration if necessary. If there is a questionable drug/alcohol screen, I may be charged for a repeat or confirmation test.
- 9) I understand that I will be tested for the presence of alcohol and other drugs in my system on a random basis according to procedures established by the Wellness & Recovery Court Team and/or treatment provider. I understand that I will be given a location and time to report for my drug test. I understand that it is my responsibility to report to the assigned location at the time given for the test. I understand that if I am late for a test, or miss a test, it will be considered a positive test and I may be sanctioned.
- 10) I understand that substituting, altering or trying in any way to change my body fluids for purposes of testing will be grounds for immediate termination from Wellness & Recovery Court.
- 11) I understand that participating in the program requires me to be alcohol and other drug free at all times. I will not possess alcohol and other drugs or alcohol and other drug paraphernalia. I will not associate with people who use or possess drugs, nor will I be present while alcohol and other drugs are being used by others. Failure to comply is grounds for sanctions or termination from the program.
- 12) I agree to be alcohol and other drug tested at any time by a police officer, probation officer, treatment provider, or at the request of the court or any agency designated by the court.
- 13) I will inform any law enforcement officer who contacts me that I am in WRC. I will inform WRC of any law enforcement contact.
- 14) I understand that I may not work as a confidential informant with any law enforcement agency while I am in the program, nor may I be made or encouraged to work as a confidential informant as a condition of my full participation.
- 15) I may not participate in the program if I am an affiliated gang member.
- 16) If on probation - I will follow all rules of Community Supervision.
- 17) I will inform all treating physicians or dental providers that I am a recovering substance abuser. I will not take narcotic or addictive drugs without approval of the WRC contingent on written documentation from the prescribing physician of an underlying medical necessity. I may receive medications as prescribed to me by a physician in a medical emergency. I will inform all treatment providers and my Community Corrections Agent of the medications that I am taking.
- 18) I agree to be responsible for what goes into my body that may affect drug test results. Before taking medication of any kind, I will check with the pharmacist to ensure that it is non-narcotic, non-addictive and contains no alcohol. I will pre-register any and all medications, prescribed or over-the-counter, with my treatment provider and with the Wellness & Recovery Court.
- 19) I agree that I will not leave any treatment program without prior approval of my treatment provider and the Wellness & Recovery Court Team.
- 20) I understand that I may dispute positive test results, but that re-testing will be at my expense if the test result is again positive.

- 21) For the purposes of regular Wellness & Recovery Court review hearings, I agree to waive my right to have my attorney of record present. I understand that I may have my attorney of record present if I choose. I understand that my case may be discussed without my attorney or the prosecutor present. I understand the Public Defender will have a representative at Wellness & Recovery Court hearings and I may consult with the representative at any time.
- 22) I understand that my individual course of treatment may include intensive-outpatient treatment, inpatient treatment, education, and/or self-improvement courses such as anger management, parenting or relationship counseling.
- 23) I understand that if I am required to participate in inpatient treatment, I may be precluded from working or from gaining employment. I further understand that within the time directed by the Wellness & Recovery Court Team, I will seek employment, job training and/or further education as approved by the Wellness & Recovery Court Team.
- 24) I agree to keep the Wellness & Recovery Court Team, treatment providers and law enforcement liaison, if any, advised of my current address and phone number at all times and whenever changed. My place of residence is subject to Team approval, and I will not leave Ashland County without prior approval from the Team.
- 25) As a condition of participation in this program, I agree to the search of my person, property, place of residence, vehicle or personal effects at any time with or without a warrant, when required by a probation agent or other law enforcement officer.
- 26) I agree to execute the Reciprocal Authorization for Disclosure of Confidential Information form and Medical Treatment Information form. I understand that any information obtained from this release will be kept apart from the Court file.
- 27) I understand that my failure to successfully complete and graduate from the Wellness & Recovery Court will result in sanctions that could include termination of a deferred plea agreement or revocation of probation, extended supervision, or parole depending upon legal status.
- 28) Each WRC participant shall be charged the sum of \$600 to participate in the program. Any of the \$600 can be earned by doing Community Service work at a rate of \$7.50/hr. It is expected that each WRC participant will pay \$50 per month commencing in Phase II, and continuing until paid in full. Additional fees might be accrued based on the WRC Team's recommended sanctions.
- 29) I agree to participate with the requirements of the WRC grant reporting expectations, such as the GPRA intake, 6-month follow-up, and discharge interviews regardless of my program status.

I have read the above contract and I understand what I have read. I am willing to enter into this agreement with the Ashland Wellness & Recovery Court.

Wellness & Recovery Court Participant

Witness

Date

Date