Authorization to Disclose
Claimant/Benefit and Protected Health Information

The Pine, Isanti, Chisago, Kanabec ("PICK") Veterans Treatment Court has made it a condition of my participation in the Treatment Court program and disposition of my pending criminal matters that I disclose to the criminal justice system information protected by federal laws: 5 U.S.C. 552a, 38 U.S.C. 5701, 42 CFR Part 2, 45 CFR Parts 160 and 164, and 38 USC §7332 (drug and alcohol abuse, HIV, and sickle cell anemia).

Therefore, I, _____ (print full name), request that the United States Department of Veterans Affairs, Veterans Benefits Administration and Veterans Health Administration disclose my claimant and/or benefit information and protected health information to the following:
PICK Veterans Treatment Court. including the coordinator, prosecutor, defense counsel, probation and all parties sanctioned by and associated with the court or jail in pre or post court proceedings.

I authorize release of the following protected health information:
Any and/or all claimant and/or benefit information and any and/or all medical and psychological information to include communication in person, by telephone, mail, encrypted email, or fax.

I certify that this request is made freely, voluntarily and without coercion and that the information on this form is accurate and complete to the best of my knowledge.

I understand that I will receive a copy of this form after I sign it.

I understand that the VA may not condition treatment, payment, enrollment, or eligibility for benefits upon my signing of this authorization.

This authorization will expire upon discharge from the PICK Veterans Treatment Court located in Pine, Isanti, Chisago, or Kanabec counties in Minnesota. I understand that I may not revoke this authorization before that date. I understand that failure to provide the Veterans Treatment Court with the appropriate authorizations may lead to my removal from the Veterans Treatment Court and the transfer of my pending criminal matters to the regular District Court venue.

_____	_____	_____
Date	Print Full Name	Last Four-SSN

_____
Signature

_____
Address

STATE OF MINNESOTA
COUNTY OF CHISAGO

DISTRICT COURT
TENTH JUDICIAL DISTRICT

State of Minnesota

v.

CONSENT TO RELEASE
PRIVATE RECORDS AND INFORMATION

_____ Case # _____

CONSENT TO RELEASE PRIVATE HEALTH, ALCOHOL/DRUG, AND MENTAL HEALTH RECORDS AND INFORMATION

My name is _____ (print full name). My date of birth is _____

1. I understand that to be considered for participation in the PICK Veterans Treatment Court, I must allow my medical, alcohol/drug treatment, and mental health providers to furnish information relating to my treatment to any member of the Veterans Treatment Court Team for the duration of my participation in Veterans Treatment Court, and by signing this agreement I agree to the disclosure of records and information.

2. I understand that my treatment records are protected under the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and 38 U.S.C. 7332, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical and treatment records are protected by federal law and regulations. I also understand that my records concerning mental health services I receive are protected by state law.

3. I understand that I may revoke this authorization at any time by written request, and by doing so I am opting out of the Veterans Treatment Court. **Otherwise, this consent will expire twenty-four months from the date executed.** I further understand that my records may be transmitted by fax and electronically.

   This document does NOT supersede any similar consent forms that I may sign specifically for the release of Veterans' Administration records or for release of any of my treatment records to the Veterans' Administration if said consent forms provide that the consent is irrevocable. In those cases, the Veterans' Administration forms shall prevail.

4. I understand that the purpose of releasing this medical, treatment, and mental health information is for the Veterans Treatment Court Team to determine my eligibility for the program; and once in the program, to determine the proper treatment placements and regimen, and to judge my progress in the program.

5. I understand that my medical and treatment information may be discussed in the Veterans Treatment Court where other participants and observers may receive the records and hear discussions about it.

6. I have read this document, or it has been read to me, and I understand its contents. By signing this Consent, I am telling the Court that I understand the rights I am waiving and agree to do so voluntarily.

DATE _____ _____
Defendant Signature

DATE _____ _____
Defendant's Attorney (if applicable)