

**Collin County District Attorney
Opioid Treatment Program (DAOTP)**

REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize and request release of confidential information regarding the educational, medical, psychiatric or psychological information, history and substance use treatment of:

FULL NAME OF PERSON ON THE RECORDS: _____

DATE OF BIRTH OF THE PERSON ON THE RECORDS: _____

INFORMATION TO BE RELEASED TO:

Donald Bell (CSCD) & Collin County District Attorney's Office
2100 Bloomdale Rd., Ste. 100
McKinney, Texas 75071
DA_opioidtreatmentprogram@collincountytexas.gov

INFORMATION TO BE REQUESTED/RELEASED/EXCHANGED: All pertinent medical and psychiatric information as it relates to administration of the Opioid Treatment Program to include but not limited to initial psychiatric/substance use assessments, treatment plans/progress, psychological reports, social history, and urinalysis reports.

_____(initials) I UNDERSTAND THAT MY RECORDS ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN AUTHORIZATION, EXCEPT WHEN OTHERWISE PERMITTED BY LAW. INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED. I UNDERSTAND THAT THE SPECIFIED INFORMATION TO BE RELEASED INCLUDES, BUT IS NOT LIMITED TO: HISTORY, DIAGNOSES, AND/OR TREATMENT OF DRUG OR ALCOHOL ABUSE AND MENTAL ILLNESS.

_____(initials) I ACKNOWLEDGE AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, AND PSYCHIATRIC INFORMATION.

THIS AUTHORIZATION WILL EXPIRE TWENTY-FOUR (24) MONTHS FROM THE DATE OF MY SIGNATURE UNLESS I REVOKE THE AUTHORIZATION IN WRITING PRIOR TO THAT TIME.

I understand and agree that no liability of any nature shall attach to the releasing organization in release of this information, or to any employee acting upon this request. I also release CSCD and the Collin County District Attorney's Office and employees from any liability of any type for any type of damages resulting from the release and subsequent use of this information. I fully understand the significance of signing this waiver and do so voluntarily.

Defendant's Signature

Date

Witness Signature

Date