DEPARTMENT OF CRIMINAL JUSTICE
AUTHORIZATION FOR ASSESSMENT
PRETRIAL DIVERSION

Defendant Name:	Jail Tower:
Book-in Number:	AIS Number:
DOB:	Age:
Race/Ethnicity:	Sex:
Email:	Phone: Alt No.:

Authorization by Defense Attorney

I acknowledge that I was contacted by the Dallas County Criminal Justice Division and that I agree that my client identified above may proceed to be assessed by the Dallas County Criminal Justice Division in order to be considered for possible case diversion.

Attorney Printed Name::	Signature:
TX Bar Number:	Date:

Authorization by Defendant

I waive my rights of confidentiality and authorize any Dallas County Criminal Justice Department personnel to request and receive information or records from any person including myself, or any agency identified below having information or records concerning my medical, psychological or psychiatric history and any information or records pertaining to diagnosis, condition or treatment of a medical, psychological or psychiatric nature including acquire immune deficiency syndrome (AIDS), human immunodeficiency viral infection (HIV) or any AIDS related complex.

I further waive my rights of confidentiality and authorize below agency, doctor, hospital, or treatment facility to disclose any and all information or records requested by any Dallas County Criminal Justice Department personnel.

- ☐ Dallas County Criminal Justice Dept.
- ☐ MetroCare
- ☐ North Texas Behavioral Health Authority
- ☐ ADAPT
- ☐ The Bridge
- ☐ Texas Dept of Health and Human Services
- ☐ U.S. Dept of Housing & Urban
- ☐ Dallas Housing Authority
- ☐ UT Southwestern Medical Center
- ☐ Nexus Recovery Center
- ☐ Parkland
- ☐ Social Security Administration
- ☐ Veteran's Administration
- ☐ Metro Dallas Homeless Alliance
- ☐ Emergency/Alternate Contact
- ☐ Homeless Management Information
- ☐ The Cottages at Hickory Crossing
- ☐ Efforts to Outcomes Data Base (ETO)
- ☐ IPS
- ☐ Homeward Bound

Family Phone: Relationship: Mother

Family	Phone:	Relationship: Mother
Family	Phone:	Relationship: Mother
Other:	Phone:	Relationship: Mother
Other:	Phone:	Relationship: Mother
Physician:	Phone:	Fax::

I further waive my rights of confidentiality and authorize Dallas County Criminal Justice Department personnel to disclose any and all acquired information or records to the following:

1. The Judge having authority over my case and the personnel of the Court.
2. Other Dallas County Community Supervision and Corrections Department involved in the supervision and maintenance of my supervision file.
3. Personnel of any department to which my case may be transferred for supervision.
4. Personnel of any residential facility in which I may be placed, including the Dallas County Judicial Treatment Center.
5. Personnel of any institution facility to which I may be committed.
6. Personnel of any treatment/diagnostic program to which I may be assigned.
7. Personnel from the District Attorney's office.
8. My attorney of record.
9. Texas Department of Criminal Justice, Community Justice Administrative Division.

I understand one purpose of, and need for, this disclosure is to inform the Dallas County Criminal District Attorney's Office and my Attorney of Record of my **eligibility** for pre-trial intervention diversion programs or post indictment plea bargain offers, including treatment recommendations. This information may be released through verbal, written or electronic communication.

I understand **the assessment will be made available to** the Dallas County Criminal Justice Department, the Dallas County Criminal District Attorney's Office and my Attorney of Record; however, should any facts pertaining to the underlying offense be disclosed during the assessment, such facts shall be redacted from the assessment and not be made available to the State nor shall such facts be used in the prosecution of the case.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient records and that recipients of the information may re-disclose it only in connection with their official duties.

I have read or have had read to me the terms and conditions of this agreement and fully understand same. I do hereby freely, knowingly, and intelligently agree to those terms and conditions.

EMERGENCY/ALTERNATE CONTACT

In the event of an emergency, or in the event that Criminal Justice Department is unable to contact me, I authorize Criminal Justice Department to contact the person below:

NAME RELATIONSHIP Spouse

PHONE:

ADDRESS:

Right to Revoke

I understand that I may revoke this authorization in writing at any time, except to the extent that the Department of Criminal Justice has relied on this authorization to use or disclose my information for the purposes solely disclosed above.

This authorization is valid for 1 year from the date it is signed. This authorization will expire on

Signature _____ Date:

Notice to Prohibit Re-disclosure of Confidential Information

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.