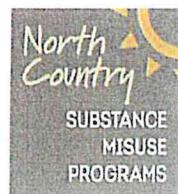




North Country  
HEALTH CONSORTIUM



**Drug Treatment Court for Grafton County  
Program Application (pg. 1 of 5)**

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_ Alias(es): \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Contact Phone #: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How long at this address? \_\_\_\_\_ Cohabitant(s): \_\_\_\_\_

Relationship(s): \_\_\_\_\_

Previous Address: \_\_\_\_\_

Next of kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Best method and time to contact you: \_\_\_\_\_

Primary Referral Source: \_\_\_\_\_ Name of Referral: \_\_\_\_\_

**Demographics:**

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Citizen Status: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Distinguishing Mark(s)? \_\_\_\_\_ Location(s): \_\_\_\_\_

**Veteran's Information:**

Have you ever served in the military?  Yes  No

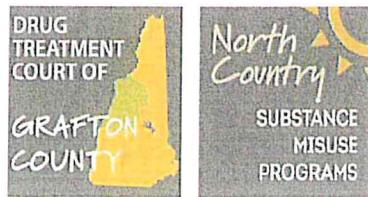
Have you ever served in combat?  Yes  No

If yes, are you affiliated with any Veteran Services?  Yes  No

**Criminal Justice Information:**

Do you have any prior convictions?  Yes  No

DATE	CHARGES	COURT



### Drug Treatment Court for Grafton County Program Application (pg. 2 of 5)

Do you have a juvenile record?  Yes  No

Current Charges: \_\_\_\_\_

Indictment # \_\_\_\_\_ Stage in Court Process: \_\_\_\_\_

Next Court Event: \_\_\_\_\_ Date: \_\_\_\_\_ Judge: \_\_\_\_\_

Date of Arrest: \_\_\_\_\_ Location of Arrest: \_\_\_\_\_

Pending charges other than those listed above?  Yes  No

If yes, explain: \_\_\_\_\_

***NOTE: Please list ALL current pending charges, including those in other states and counties. Failure to do so may result in your application being denied.***

Attorney for current charges: \_\_\_\_\_ Phone: \_\_\_\_\_

Attorney for pending charges: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently on probation or parole?  Yes  No

If yes, name of your PPO: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been convicted of a violent crime?  Yes  No

Are you currently incarcerated?  Yes  No If yes, date of incarceration: \_\_\_\_\_

Do you have any Detainers?  Yes  No Jurisdiction: \_\_\_\_\_

#### **Health & Substance Abuse History**

I have a problem with:  Drugs  Alcohol  Both drugs and alcohol Are you an IV user?  Yes  No

Age of first Use: \_\_\_\_\_ What did you use? \_\_\_\_\_ Method of use: \_\_\_\_\_

First drug of choice: \_\_\_\_\_ Age of use: \_\_\_\_\_

Method of use: \_\_\_\_\_ Date of last use: \_\_\_\_\_

Second drug of choice: \_\_\_\_\_ Age of use: \_\_\_\_\_

Method of use: \_\_\_\_\_ Date of last use: \_\_\_\_\_

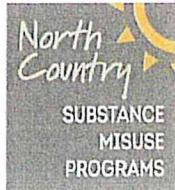
Third drug of choice: \_\_\_\_\_ Age of use: \_\_\_\_\_

Method of use: \_\_\_\_\_ Date of last use: \_\_\_\_\_

Have you ever been treated for a substance abuse problem?  Yes  No



North Country  
HEALTH CONSORTIUM



**Drug Treatment Court for Grafton County  
Program Application (pg. 3 of 5)**

Number of previous substance abuse admissions? \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient

Number of previous mental health admissions? \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient

If there has been a diagnosis, please describe here: \_\_\_\_\_

Have you ever been tested for HIV?  Yes  No Do you know the results?  Yes  No

Do you have any current serious medical problems?  Yes  No

Please describe here: \_\_\_\_\_

What, if anything, have you been diagnosed with? \_\_\_\_\_

Are you currently on any prescription medications?  Yes  No

Please list here: \_\_\_\_\_

**Personal Information:**

Highest level of education completed? \_\_\_\_\_ Post-secondary schooling?  Yes  No

Do you have a GED?  Yes  No Are you interested in getting your GED?  Yes  No

Do you have a driver's license?  Yes  No Are there any restrictions?  Yes  No

Please explain: \_\_\_\_\_

Do you have a vehicle or access to a vehicle?  Yes  No

Will transportation be an issue for you?  Yes  No

Do you have any special needs? If yes, please describe: \_\_\_\_\_

**Financial and Employment Information:**

Monthly income: \_\_\_\_\_ Source of income: \_\_\_\_\_

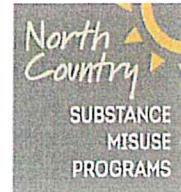
Are you currently employed?  Yes  No Where? \_\_\_\_\_

Is your current income sufficient to meet your bills?  Yes  No

Do you have Health Insurance?  Yes  No Name of Insurance carrier \_\_\_\_\_



North Country  
HEALTH CONSORTIUM



**Drug Treatment Court for Grafton County  
Program Application (pg. 4 of 5)**

**Child Care Needs:**

Do you have any children?  Yes  No If yes, what are the names and ages: \_\_\_\_\_

Do you currently have custody of these children?  Yes  No

**Are you in immediate need of any of the following services?**

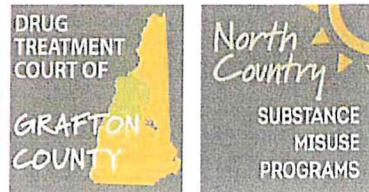
• <b>Housing:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	• <b>Food:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	• <b>Pregnancy Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
• <b>Medical Care/Insurance:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	• <b>Dental Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	• <b>DMV Information:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
• <b>Domestic Violence Info:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	• <b>Educational Assistance:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	• <b>Health and Nutrition:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

In your own words, explain briefly why you would like to enter into the Drug Treatment Court Program and what you hope to gain from it: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you like to do in your free time? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Drug Treatment Court for Grafton County  
Program Application (pg. 5 of 5)**

---

---

---

---

---

*Please Read Carefully*

I understand it is my responsibility to return any calls received by the Therapist attempting to schedule an appointment. Failure to schedule or appear for this appointment could result in my application for the Drug Treatment Court being denied. I am aware that the Therapist will make a decision as to the level of care that is needed.

SIGNATURE OF DEFENDANT: \_\_\_\_\_ Date: \_\_\_\_\_

This application will not be considered for admission into Drug Treatment Court unless the following certification has been completed. I hereby certify that I have fully explained the Drug Treatment Court program and that I have reviewed with my client the contents of the Drug Treatment Court Participant Handbook and Participation Agreement.

Defense Counsel Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this I acknowledge and agree to follow everything in the Drug Treatment Court Handbook. If I have any questions, I will contact the Drug Treatment Court Team.

---

Signature \_\_\_\_\_ Date \_\_\_\_\_

Defense Counsel Date



## CONSENT FOR THE RELEASES OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County** to have reciprocal verbal communication and to exchange written records with:

<input type="checkbox"/> Robert Akesson (Coordinator), Drug Treatment Court of Grafton County	<input type="checkbox"/> Monica Gasey (Public Defender), NH Public Defenders	<input type="checkbox"/> Marcie Hornick (County Attorney)	<input type="checkbox"/> Stacie Leclerc Blue Heron Neurofeedback and Counseling, LLC
<input type="checkbox"/> Alicia Bolyard (Case Manager), Drug treatment Court of Grafton County	<input type="checkbox"/> Amanda Perry (Probation Officer), Drug Treatment Court of Grafton County	<input type="checkbox"/> Lydia McKenzie, DNP	<input type="checkbox"/> Susan Bailey/ Blue Heron Neurofeedback and Counseling, LLC
<input type="checkbox"/> Shawn Cannizzaro (Case Manager), Drug Treatment Court of Grafton County	<input type="checkbox"/> Lawrence MacLeod (Judge), Grafton County Superior Court	<input type="checkbox"/> Paul Smith (Chief of Police), Littleton Police Department	<input type="checkbox"/> Gary Richard/ Blue Heron Neurofeedback and Counseling, LLC
	<input type="checkbox"/> Viktoriya Kovalenko (Clerk of Courts), Grafton County Superior Court	<input type="checkbox"/> Bob Thompson (Program Director), NCHC	<input type="checkbox"/> Rhonda Bishop/Blue Heron Neurofeedback and Counseling, LLC
		<input type="checkbox"/> Other _____	

### I DO GIVE CONSENT (Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

### I DO GIVE CONSENT (Initial line)

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.	I UNDERSTAND (Initial line)
2. I 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 will remain in force for one (1) year.	_____
3. I understand that my continued participation in the Grafton County Drug Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.	_____
4. I understand that I will be asked to renew this consent, at a minimum, on an annual basis, throughout the course of my participating in the Grafton County Drug Court Sentencing Program.	_____
5. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.	_____

Participant's Signature

Date

Signature of Witness

Date

Name & Title of Witness (PRINTED)



**CONSENT FOR THE RELEASES OF CONFIDENTIAL TREATMENT INFORMATION**

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County** to have reciprocal verbal communication and to exchange written records with:

<input type="checkbox"/> Tara Heater (County Attorney)	<input type="checkbox"/> Renee Sargent (Public Defender), NH Public Defenders
<input type="checkbox"/> James Simpson (County Attorney)	<input type="checkbox"/> Jennifer Szafir (Public Defender), NH Public Defenders
<input type="checkbox"/> Jason Novak (Public Defender), NH Public Defenders	

I DO GIVE CONSENT  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

I DO GIVE CONSENT  
(Initial line)

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.

2. I 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 will remain in force for one (1) year.

3. I understand that my continued participation in the Grafton County Drug Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.

4. I understand that I will be asked to renew this consent, at a minimum, on an annual basis, throughout the course of my participating in the Grafton County Drug Court Sentencing Program.

5. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.

I UNDERSTAND  
(Initial line)

Participant's Signature

Date \_\_\_\_\_

Signature of Witness

Date \_\_\_\_\_

Name & Title of Witness (PRINTED)



### CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM / DD / YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

Other: Attorney ~

*(Please write your attorney's name)*  
I DO GIVE CONSENT \_\_\_\_\_ I DO GIVE CONSENT \_\_\_\_\_  
(Initial line) (Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

#### I UNDERSTAND

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment. \_\_\_\_\_ (Initial line)
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program. \_\_\_\_\_
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider. \_\_\_\_\_
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations. \_\_\_\_\_

Participant's Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_



### CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant) of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

Other: Grafton County HOC

I DO GIVE CONSENT  
(Initial line)

I DO GIVE CONSENT  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

#### I UNDERSTAND

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program.
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.

Participant's Signature

Date

Signature of Witness

Date



## CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant) of the **Drug Treatment Court Sentencing Program for Grafton County** to include **Blue Heron Neurofeedback and Counseling** which is the clinical treatment provider for DTC, to have reciprocal verbal communication and to exchange written records with:

Other: NH Detox

**I DO GIVE CONSENT**  
(Initial line)

1. Addiction Severity Index (ASI) Assessment \_\_\_\_\_
2. Bio-Psycho-Social Assessment \_\_\_\_\_
3. Current Medications \_\_\_\_\_
4. Result of Psychological Evaluation(s) \_\_\_\_\_
5. Discharge Summary \_\_\_\_\_
6. Medical and Physical Examination Results \_\_\_\_\_
7. Other Medical Results \_\_\_\_\_
8. Admissions/Intake Summary \_\_\_\_\_
9. Program Attendance (session, type, frequency) \_\_\_\_\_

**I DO GIVE CONSENT**  
(Initial line)

10. Psychiatric or Psychological Progress Reports \_\_\_\_\_
11. Summary Diagnosis \_\_\_\_\_
12. Current Symptoms and Treatment Plan \_\_\_\_\_
13. Statement of Treatment Prognosis \_\_\_\_\_
14. Statement of Treatment Status/Progress \_\_\_\_\_
15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration) \_\_\_\_\_
16. Employment \_\_\_\_\_
17. \_\_\_\_\_

**I UNDERSTAND**

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment. \_\_\_\_\_ (Initial line)
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program. \_\_\_\_\_
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider. \_\_\_\_\_
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations. \_\_\_\_\_

Participant's Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_



### CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County** to include **Blue Heron Neurofeedback and Counseling** which is the clinical treatment provider for DTC, to have reciprocal verbal communication and to exchange written records with:

Other: Avenues

I DO GIVE CONSENT  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

I DO GIVE CONSENT  
(Initial line)

I UNDERSTAND

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.	(Initial line)
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program	_____
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.	_____
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.	_____

Participant's Signature

Date

Signature of Witness

Date



## CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)  
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue  
Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to  
have reciprocal verbal communication and to exchange written records with:

Other: Live Free

I DO GIVE CONSENT  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

I DO GIVE CONSENT  
(Initial line)

I UNDERSTAND

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.	(Initial line)
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program.	_____
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.	_____
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.	_____

Participant's Signature

Date

Signature of Witness

Date



### CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

Other: White Mountains Recovery Home

I DO GIVE CONSENT  
(Initial line)

I DO GIVE CONSENT  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

#### I UNDERSTAND

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment. (Initial line) \_\_\_\_\_
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program. \_\_\_\_\_
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider. \_\_\_\_\_
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations. \_\_\_\_\_

Participant's Signature

Date

Signature of Witness

Date



### CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)

of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

Other: Saving Grace

I DO GIVE CONSENT  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

I DO GIVE CONSENT  
(Initial line)

I UNDERSTAND

(Initial line)

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program.
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.

Participant's Signature

Date

Signature of Witness

Date



## CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

I, \_\_\_\_\_ do hereby consent and authorize any and all of the team members  
(Printed Name of Participant)  
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

Other: Head rest

**I DO GIVE CONSENT**  
(Initial line)

1. Addiction Severity Index (ASI) Assessment	_____	10. Psychiatric or Psychological Progress Reports	_____
2. Bio-Psycho-Social Assessment	_____	11. Summary Diagnosis	_____
3. Current Medications	_____	12. Current Symptoms and Treatment Plan	_____
4. Result of Psychological Evaluation(s)	_____	13. Statement of Treatment Prognosis	_____
5. Discharge Summary	_____	14. Statement of Treatment Status/Progress	_____
6. Medical and Physical Examination Results	_____	15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration)	_____
7. Other Medical Results	_____	16. Employment	_____
8. Admissions/Intake Summary	_____	17. _____	_____
9. Program Attendance (session, type, frequency)	_____		

**I DO GIVE CONSENT**  
(Initial line)

**I UNDERSTAND**

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.	(Initial line)
2. I 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 will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program.	_____
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.	_____
4. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.	_____

Participant's Signature

Date

Signature of Witness

Date