Application Packet for the Albany County Court Supervised Treatment Program

515 East Ivinson
Suite 107
Laramie, WY 82070
307-721-1850

If you need help filling out or completing the application packet, please contact Claire Flaherty at 307-721-1826

For Office Use Only

Status	Date
Received	
Vetted	
ASI Requested	
DOC Review Requested	
ASI Received	
DOC Review Received	
Letter of Acceptance/Denial Sent	

What is the Albany County Court Supervised Treatment Program?

The Albany County Court Supervised Treatment Program is a treatment-focused program targeted to offer intensive rehabilitation services to individuals involved with the criminal justice system who have been identified as having a drug and/or alcohol addiction. The Drug Court program creates an environment with clear, certain, and definite rules that are easy to understand, based on the participant's performance, and measurable results. Compliance is wholly within the participants' control.

The Albany County Court Supervised Treatment Program is designed to last a minimum of thirteen months, which is divided into different supervision and treatment phases. Each supervision level and treatment phase has been developed to help the participant overcome certain issues that are usually prevalent at different stages of substance abuse treatment.

Any person who meets the admission criteria for the Drug Court program may volunteer to participate in the program. However, once a person has been admitted into the program, their participation in every facet of the program is MANDATORY. Any person may request at any time to be released from the program, but it should be noted that further adjudication may follow, which may include the imposition of any underlying sentence.

Elements of the Albany County Court Supervised Treatment Program

- Rapid Intervention
- Immediate Access to Treatment
- Systematic and Coordinated Approach to Treatment
- Judicial Leadership
- Frequent and Direct Contact with Drug Court Team Members
- Use of Incentives and Sanctions

What is including in the referral packet?

- Drug Court Questionnaire
- Program Qualification Information
- Consent to Release Confidential Information for Referral Purposes
- Program Understanding, Waivers, and Agreements

Please read and sign any and all paperwork in this packet and turn it into either your Probation and Parole Agent, the Detention Center staff, or to the Albany County Court Supervised Treatment Program Case Manager (307-721-1826) or Director (307-721-1850), located in suite 304 in the Albany County Courthouse.

The packet must be completed in its entirety or the person requesting admission may not be reviewed.

Albany County Court Supervised Treatment Program
Program Qualification Information

In order to qualify for the Albany County Court Supervised Treatment Program, the referred person must demonstrate a significant drug and/or alcohol problem. The referred person must also be willing to undergo a substance abuse evaluation, an initial interview by any member of the Drug Court Team, and consent to a background check. All final decisions for acceptance into the Albany County Court Supervised Treatment Program will be made by the Team.

Who does qualify for the Albany County Court Supervised Treatment Program?

- Be a resident of Albany County.
- Felony Drug Charges – Any person who may be charged with possession of a controlled substance in the amount prescribed as a felony according to Wyoming State statute. May also include persons charged with 3rd time simple possession in which that charge is a felony, and/or any person charged with prescription fraud.
- Felony Probation or Parole Revocation – Any person who is on felony probation or parole who is facing possible revocation for continued drug use, positive urinalysis tests, drug possession, and in some instances new criminal charges.
- Felony Property Crime(s) – Any person who is charged with crimes against another person's property when those crime(s), or associated criminal behavior is/are related to supporting a drug addiction. Felony property crimes may include burglary, felony theft, check fraud, credit fraud, forgery, etc.
- Misdemeanor Offense(s) – Any person who is charges with a possession of illegal substance, driving under the influence, or is charged with an offense in which substance use is a component or underlying problem related to the offense.

Who may not qualify for the Albany County Court Supervised Treatment Program?

- Violent Offenses – Any person who's underlying charge(s) involves any use of violence in the commission of their crime. The Albany County Court Supervised Treatment Program defines violence as follows:
  A person who is charged with, or convicted of, an offense during the course of which; (1) The person carried, possessed, or used a firearm or other dangerous weapon. (2) The person used force against another person. (3) Death, or serious bodily injury, occurred to any person, without regard to whether any of the circumstances described above is an element of the offense, or conduct of which, or for which the person is charged with or convicted of. It may also include persons whom have been convicted of violent crimes in the past, regardless if those violent offenses were misdemeanors or felonies.

- Severe Mental Illnesses or Diminished Mental Capacity – Any person who may suffer from severe mental illness in which treatment requires regulated, consistent, and/or intensive drug therapy. It may also include persons who may not have the cognitive ability or awareness to properly participate in the intense probationary requirements of the program and/or the intensive nature of the drug treatment program.

- Felony Drug Trafficking Offenses – Any person who has been charged with or convicted of felony drug trafficking offenses. A felony drug trafficking offense may be defined as any person who was selling, in possession of, or distributing narcotics in which a reasonable inference may be made that those activities go beyond the scope of personal use.

- Individuals Charged or Convicted of Sex Crimes – Any person who has been charged with, or convicted of, Sexual Assault as defined pursuant to W.S.S. 6-2-302 through 6-2-319; and/or any person charged with an Offense Against the Family as defined pursuant to 6-4-301 through 6-4-304 and 6-4-401 through 6-4-402.

All persons seeking placement in the Albany County Court Supervised Treatment Program must have a residence that is free of drugs and/or alcohol, firearms, or other dangerous weapons. The residence must also be free of any person(s) who may use drug and/or alcohol, or being in possession of firearms, or other dangerous weapons. The Albany County Court Supervised Treatment Program reserves the right to determine what may be or may not be an acceptable residence.

Albany County Court Supervised Treatment Program reserves the right to change any qualifying or disqualifying criteria without notice. If you believe that your client may be a possible client for the Albany County Court Supervised Treatment Program, please feel free to contact the Albany County Drug Court Director at (307)721-1850, or Case Manager at (307) 721-1826.

DRUG COURT PARTICIPANT PERSONAL INFORMATION SHEET

Date: _____ Referred By: _____

Full Legal Name: _____ Nickname: _____

Date of Birth: _____ Social Security Number: _____

Age: _____ Birthplace: _____ Race/Ethnicity: _____ Gender: _____

Current Address:_____

Phone: _____ Email: _____

Probation Agent:_____ Defense Attorney: _____

Currently in Jail: **Yes _____No _____**

Current/Pending Charges:

_____

Describe/Explain how you got the current/pending charges:

_____

_____

_____

_____

Current employment status (mark one)?

___Disabled unemployed
___Full-time employed
___Homemaker (adult not in workforce)
___Inmate in institution
___ Full-time Student
___Other (Please, explain)
_____

Employment type (mark one)?

___Part-time employed
___Retired
___Seasonal employed
___Self-employed
___Student
___Unemployed (employable, no work available

Employer _____

Payment base

_____Annually _____ Hourly

- On average, how many hours a day do you work _____
- On average, how many hours a week do you work _____
- Average monthly income is _____

Paychecks are:

_____ Weekly _____ Every two weeks _____ Monthly

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE

PART I: Basic Information, Family Relationships

1. Do you have a valid driver's license? Yes _____No _____ Issuing State_____
   a. If not, why? _____

2. Do you own a vehicle? Yes _____No _____
   a. If no, what is your plan for transportation?
      _____
   b. If yes, what is the year, make, and model of your vehicle?
      _____

3. What is the highest grade in school that you completed? _____

4. Do you have a high school diploma or GED? _____

5. Where and when did you get it? _____

6. Please pick a category for your current primary residence (mark one).
   __Homeless
   __Staying with friends
   __Rent a room
   __Live with family in apartment
   __Live with family in a single-family home
   __Rent my own residence
   __Own my residence (including mortgages)

7. How many times have you moved in the last year?
   __None
   __1-2
   __3-4
   __5 or more

8. Please circle the appropriate response: I am
   Single
   Married (How long? _____)
   Divorced (How long? _____)
   Separated (How long? _____)
   In a longstanding relationship (How long? _____)

9. My significant other is named: _____

10. My significant other's address is: _____

11. My significant other's phone number is: _____

12. Please list all names of your children and stepchildren (those you are legally and/or financially responsible for).

First and Last Name	Age	Relation to You	Custody Status	Do you pay child support?	Monthly payment?	Are you current or do you owe back payment?

13. Please identify family members, their age, your relationship with each, and where they currently reside.

Please list all family members, to include mother, father, step and/or foster parents, brothers, sisters, and half/step siblings	Age	Please identify how your relationship is with each family member					City & State where they reside:
		Very Good	Good	Fair	Poor	No Relationship	

PART II: Substance Use and Mental Health History

14. How old were you when you first used alcohol? _____

15. How old were you when your first used an illegal drug? _____

16. How old were you when you started using alcohol/drugs regularly? _____

17. Does your current drug use involve opioids and/or heroin? Yes _____No _____

18. What is your primary drug of choice (Alcohol, marijuana, cocaine, methamphetamines, heroin, other; please specify if "other")?
    _____

19. What is your second drug of choice (Alcohol, marijuana, cocaine, methamphetamines, heroin, other; please specify if "other")?
    _____

20. What is your third drug of choice (Alcohol, marijuana, cocaine, methamphetamines, heroin, other; please specify if "other")?
    _____

21. With whom do you use drugs and/or alcohol with?
    __ Friends
    __Family
    __No one, you use by yourself

22. Have you ever used drugs or alcohol with:
    Your parents? Yes _____No _____
    Spouse? Yes _____No _____
    Siblings? Yes _____No _____
    Children? Yes _____No _____

23. Have you ever used needles to get high? Yes _____No _____

24. What drug(s) would you say has caused you the most trouble (please list as many as you want)?
    _____

25. How much do/did you spend on alcohol/drugs:
    per day ____ per week _____ per month _____

26. Please answer the questionnaire below:

Substance	Have you ever used (Y/N)?	Age of first use	Frequency of use (daily, weekly, monthly)?	How did you use? List all that apply (smoke, IV, nasal, etc.)	How much were you using at the height of your problem with this substance?	Approximate date of last use
Marijuana						
Methamphetamines and/or other amphetamines						
Cocaine/Crack						
Heroin						
Alcohol						
Spice						
Hallucinogens, Psychedelics Please specify:						
Inhalants						
Prescription Pills (Please specify):						
Other (Please specify):						
Other (Please specify):						

27. Have you had an ASI, ASAM, or other evaluation completed in the past 6 months? Yes___ No___

a. If yes: Location _____ Month _____Year _____
Results _____

28. Have you ever been diagnosed with a mental health disorder? Yes ___No ___
    a. What was the diagnosis? _____
    b. Are you currently receiving psychiatric treatment for your mental health disorder? Yes____ No_____
    c. What is the name of your mental health treatment provider? _____

29. Have you ever received outpatient substance abuse and/or mental health treatment? Yes _____No _____
    a. If yes, please fill out table with details

Age	Name & dates of outpatient treatment center/program	Identify the substance or mental health issue you sought treatment for	Did you successfully complete?	Anything important the team should know about this experience?

30. Have you ever been to residential (inpatient) treatment? Yes _____No _____
    a. If yes, please fill out table with details

Age	Name & dates of inpatient treatment center	Identify the substance or mental health issue you sought treatment for	Did you successfully complete?	Anything important the team should know about this experience?

31. What medications have you, or are you currently, taking? _____
    _____

32. Have you, or are you currently, enrolled in a Medicated Assisted Therapy program such as Suboxone, Buprenorphine, or Naloxone (MAT)? Yes___ No ___

a. Which medications are you taking through the MAT program, and who is your prescribing treatment provider?_____
_____

33. Do you currently smoke cigarettes? Yes _____ No _____

PART III: Personal and Family Criminal History

34. Please describe your past criminal history.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

35. Would you consider one or both of your parents to be alcoholics? Yes _____No _____
36. Do either of your parents use illicit drugs? Yes _____No _____
    a. If yes, list drugs used:
    _____

37. Does anyone in your family have a criminal record? Yes _____No _____
    a. If yes, provide details:
    _____

38. At what age did you commit your first criminal act? _____
    a. Briefly explain what happened:

    _____

    _____

39. At what age did you first get arrested or cited? _____
    a. Briefly explain what happened:

    _____

    _____

40. Have you ever been charged with a crime of violence? Yes _____No _____
    a. If yes, how many of these were fighting/assault charges? _____
    b. If yes, how many of these were domestic violence charges? _____

41. How many times have you been convicted of a felony? _____
    a. What felonies have you been convicted of?

    _____

42. Are you currently under the supervision of Probation & Parole? Yes __No __
    a. If yes, who is your Probation Agent? _____

43. How many times have you been sentenced to a state or federal prison? _____
    a. For what were you convicted? _____

44. How much total time have you served in state or federal prison? _____

45. How many times have you been sentenced to a jail? _____
    a. For what were you convicted? _____

46. How much total time have you served in a jail? _____

47. How much time have you served in an Adult Community Corrections (ACC)? _____

48. Have you ever been on probation or parole? Yes _____No _____
    a. If yes, was it revoked? Yes _____No _____
    b. How many times has it been revoked? _____
    c. Explain:

    _____

    _____

49. How much total time have you served on probation or parole? _____

50. Have you ever been charged with escape from a prison, jail, or halfway house? Yes _____No _____

51. Have you ever absconded from your probation or parole? Yes _____No _____
    a. If yes, what was your reason for absconding?_____

52. Does anyone you live with abuse drugs or alcohol? Yes _____No _____
    a. If yes, please explain:
    _____
    _____

53. Has your spouse/partner, former spouse/partner, or anybody you live with, ever been incarcerated for 30 days or longer? Yes _____No _____
    a. If yes, please explain:_____
    _____

54. Have any of your friends or other family members been incarcerated for 30 days or longer?
    Yes _____No _____
    a. If yes, please explain:_____
    _____

55. Have your parents/stepparents/foster parents ever been abusive or neglectful to you?
    Yes _____No _____
    a. If yes, please explain:_____

56. Have your parents/stepparents/foster parents ever been abusive to other family members?
    Yes _____No _____
    a. If yes, please explain:_____
    _____

57. Has your spouse/partner, or anybody you live with, been treated for a drug or alcohol problem, or gone through detox? Yes _____No _____
    a. If yes, explain:_____
    _____

58. Have any of your friends or other family members been treated for a drug or alcohol problem, or gone through detox? Yes _____No _____
    a. If yes, please explain:_____

<u>PART IV:</u> Medical History

59. Do you have health insurance? Yes _____No _____

a. If yes, who is your insurance company?_____

60. Do you have Medicaid? Yes _____No _____

61. Do you have any chronic medical problems that continue to interfere with your life? Yes _____No _____
    a. If yes, please explain:_____
    _____

62. Do you take prescribed medication on a regular basis for a physical problem? Yes _____No _____
    a. If yes, please explain:_____
    _____

63. Do you receive financial compensation (pension, disability, etc.) for a physical disability?
    Yes _____No _____
    a. If yes, please explain:_____
    _____

64. Within the past year, please describe your concerns with the following symptoms (not as a result of drug/alcohol use or during periods of withdrawal):

Symptoms	**Extremely Concerned**	**Very Concerned**	**Concerned**	**Somewhat Concerned**	**Not Concerned**
Serious depression					
Serious anxiety					
Trouble concentrating					
Trouble understanding					
Seeing things that are not real					
Hearing voices that are not real					
Trouble controlling anger					
Thoughts of suicide					
Other (please explain):					

Letter of Application

The Albany County Court Supervised Treatment Program is a volunteer program, and the Drug Court Team reserves the right to accept or deny your application for placement into the program for any reason. This page is your opportunity to explain to the Drug Court Team the reasons why you want placement into Drug Court and what you hope to gain from participating in the Drug Court program. You may attach additional pages if necessary.

Proposed Residence for Drug Court Supervision

Proposed address #1

_____

- Contact Person for this address (whose name is the lease in?) _____
- Contact Person's phone number _____
- Your relationship with this person_____
- Landlord/Property Owner's name and phone number _____
- Names and ages of all people in the home

  _____

  _____
- Is this state or federal funded housing? YES ____ NO ____
- Is this a rental? YES____ NO___ If yes, provide contact information for the property manager

  _____
- Any back rent and/or utilities owed? YES____ NO___

Proposed address #2

_____

- Contact Person for this address (whose name is the lease in?) _____
- Contact Person's phone number _____
- Your relationship with this person_____
- Landlord/Property Owner's name and phone number _____
- Names and ages of all people in the home

  _____

  _____
- Is this state or federal funded housing? YES ____ NO ____
- Is this a rental? YES____ NO___ If yes, provide contact information for the property manager

  _____
- Any back rent and/or utilities owed? YES____ NO___

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Agreements

1. Will you sign a waiver of confidentiality so the Drug Court team can communicate with your current treatment provider?
   Yes _____No _____ Initials_____

2. Do you consent to sign whatever releases that may be necessary so the Drug Court team can receive and review your most recent substance abuse assessment?
   Yes _____No _____ Initials_____

3. Do you consent that the Drug Court team may restrict the locations where you may work to the city of Laramie or Albany County?
   Yes _____No _____ Initials_____

4. Do you consent that your employment may not interfere with your participation in the Drug Court program and that you will notify your employer of your participation in the Drug Court program?
   Yes _____No _____ Initials_____

5. Do you consent that any member of the Drug Court team may conduct a work-verification on you at any time and that those checks may also be completed by law enforcement?
   Yes _____No _____ Initials_____

6. Do the other persons with whom you will live with know that you may be a participant in the Drug Court program?
   Yes _____No _____ Initials_____

7. Do the other residents that you plan to live with know that you, your residence, and/or your vehicles shall be subject to search at any time by probation agents, law enforcement, or any other member of the Drug Court team members?
   Yes _____No _____ Initials_____

8. Do the people you plan to live with agree to keep the residence free of alcohol, illegal drugs, or other substances that may be prohibited by your probation agent (Products include, but are not limited to: medication or other products that contain alcohol, certain over-the-counter-medication that can be abused if used inappropriately, SPICE, CBD, Kratom, other products that may contain synthetic THC, and/or any other product that could be abused)?
   Yes _____No _____ Initials_____

9. Do you consent that the Drug Court team may restrict person(s) with whom you may reside if that person(s) uses or possesses alcohol, illegal drugs, or banned substances?

Yes _____No _____ Initials_____

10. Do you consent that the Drug Court team may require you to change your residence because of the presence of alcohol, illegal drug, or other prohibited substance use by other residents?
Yes _____No _____ Initials_____

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Instructions: Please answer the questions below by either checking YES or NO.

1. During the last year, did you notice that the same amounts of drugs or alcohol didn't have the same affect they used too, and that you had to use more in order to get the same affect?
   YES ____ NO ____

2. During the past year, have you experienced any physical distress when you quit drinking or taking drugs, or have you found yourself using more to avoid withdrawal symptoms such as hangovers or other physical symptoms?
   YES ____ NO ____

3. During the past year, have you used more alcohol or drugs, or used over a longer period of time than you had originally planned?
   YES ____ NO ____

4. During the past year, have you given up any work, family or leisure time activities due to your use of alcohol or drugs?
   YES ____ NO ____

5. During the past year, have you tried unsuccessfully to control or cut down your use of substances?
   YES ____ NO ____

6. During the last year have you continued to use alcohol or drugs despite knowing that you have a physical or emotional problem that is caused or made worse by your use of substances?
   YES ____ NO ____

7. During the past year, has your use of alcohol or drugs contributed to difficulty or inability to meet your responsibilities at home, work, or school?
   YES ____ NO ____

8. During the past year, have you used alcohol or drugs, even when your use could be putting yourself in danger (such as when driving, participating in sports, or operating heavy machinery)?
   YES ____ NO ____

9. During the past year, has your drug or alcohol use led to problems with the legal system, such as DUI, Drunk and Disorderly arrests, being picked up for drug possession, etc.?
   YES ____ NO ____

10. During the past year, have you continued to use alcohol or drugs even though this use has contributed to problems in relationships with others, such as arguments with friends or family, physical fights, etc.?
    YES ____ NO ____

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Confidentiality of Albany County Court Supervised Treatment Program's Participant's Drug and/or Alcohol Treatment Records

I understand that the confidentiality of my drug and/or alcohol treatment records maintained by the Albany County Court Supervised Treatment Program, the Albany County Drug Court Team, and its designees are protected by federal law. The Albany County Court Supervised Treatment Program, the Albany County Drug Court Team, and its designees may not discuss to any person outside of the Albany County Drug Court program any information identifying me as a participant in the Albany County Drug Court program unless:

(1) You submit in writing your consent.
(2) The disclosure is allowed by a Court Order.
(3) The disclosure is made to medical personnel in a medical emergency
(4) The disclosure is for designated personnel for research, audit, or program evaluation.
(5) The disclosure is allowed for case management purposes.

I understand that any violation of the confidentiality of drug and/or alcohol treatment records disclosure requirements is a federal crime. I understand that I am obligated to report suspected violations to the appropriate authorities in accordance with federal regulations.

I understand that federal laws and regulations concerning confidentiality of drug and/or alcohol treatment records does not protect any information about crime(s) committed by me, or any other Albany County Drug Court program participant, when such crime(s) is/are committed at the program location(s), or against the staff of the Albany County Drug Court, or its designees.

I understand that federal laws and regulations concerning drug and/or alcohol treatment records does not protect any information concerning suspected child abuse and/or neglect and I understand that any credible allegations made to the Albany County Court Supervised Treatment Program, the Albany County Drug Court Team, and its designees will be reported to the proper authorities for further investigation. (For further information please refer to 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal law and 42 C.F.R. Part 2 for regulations.)

By signing this acknowledgement concerning the confidentiality of my drug and/or alcohol treatment records, I understand all of the above requirements concerning the release of such information, and/or I have had it explained to me by my attorney to my satisfaction.

_____ _____

Printed Name Date

_____

Signature

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Drug Court Referral:
Consent to Release Confidential Substance Abuse Treatment Information

I understand that the purpose of this disclosure is to inform the Albany County Drug Court Team which includes the Judge, the Drug Court Coordinator, Assistant District Attorney, Assistant Public Defender, Law Enforcement Personnel, Probation and Parole personnel, the treatment provider, and other persons designated by the Albany County Drug Court Team of your suitability and eligibility for drug and/or alcohol treatment through the Albany County Court Supervised Treatment Program.

I understand that my eligibility for treatment through the Albany County Drug Court program may be discussed in Albany County Drug Court staff meetings, or in open Court. I also understand that your eligibility for the Albany County Drug Court program may involve a drug and alcohol evaluation, background check, placement investigation, or other criteria decided upon by the Albany County Drug Court Team.

I understand that this consent to release confidential information will remain in effect and cannot be revoked by me until there has been a formal termination of my involvement with the Albany County Drug Court program, such as, the discontinuation of all Court supervision, my successful completion of all the criteria of the Albany County Drug Court program, or my unsuccessful termination from the Laramie County Drug Court program.

I understand that any disclosure of confidential information concerning me to other outside agencies by the Albany County Drug Court, and/or the Albany County Drug Court Team, must be in compliance with federal laws 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 concerning confidentiality of substance abuse patient records.

I have read and understand all of the above requirements concerning the release of confidential substance abuse treatment information and/or I have had the contents of this document explained to me to my satisfaction. By signing this consent, I give the Albany County Drug Court, the Albany County Drug Court Team, and its designees, permission to my confidential substance abuse treatment information for referral purposes.

_____ _____
Print Name Date

_____
Signature

ALBANY COUNTY COURT SUPERVISED TREATMENT PROGRAM BASIC UNDERSTANDING, WAIVERS, AND AGREEMENTS

Defendant/Participant's Legal Name: _____

Preferred Name (if different): _____

Home Address: _____

Mailing Address: _____

SSN: _____ DOB: _____

Phone Number: (Home/Cell) _____(Work) _____

I understand that to be accepted into the Albany County Court Supervised Treatment Program (ACCSTP or Program) as a Participant I must complete the ACCSTP Application Packet, have a letter of acceptance issued by the ACCSTP Program Director, and have my participation in ACCSTP included as a condition of my probation within my Sentence/Order from my sentencing Court. Further, I understand and consent to the following waivers, terms, and conditions of my participation in the ACCSTP:

1. **LEGAL WAIVER:** I do hereby release and forever discharge the ACCSTP Judge, the Albany County Attorney's Office, ACCSTP Defense Counsel, Law Enforcement personnel, Department of Corrections Probation & Parole personnel, ACCSTP staff, ACCSTP Treatment Team, and their respective heirs, successors, executors, administrators, employees, and assigns from any and all claims of any kind or nature whatsoever, either in law or in equity, arising out of my acceptance into, participation in, or termination from the Program and do expressly release and forever hold them harmless from any criminal or civil action which I may have a right to bring as a result of my acceptance to, participation in, or termination from the ACCSTP. (___)

2. **RELEASE OF INFORMATION:** I agree to complete any requested diagnostic evaluations for the development of my substance abuse treatment program as may be ordered by the Court or required by the Program. I hereby authorize release of all treatment information by any evaluator to the Court and the ACCSTP. Any such information may be considered by the Court and ACCSTP in deciding whether I enter into or remain in the Program. (___)

3. **STATUS OF PROGRAM:** I have no legal right to participate, or continue to participate, in the ACCSTP. At any time the Program may end or be reduced, or I may be removed from any further participation in it. (___)

4. **PROGRAM LENGTH:** The Program is developed to last a minimum of thirteen (13) months and a maximum of thirty-six (36) months, achieve a minimum of four (4) consecutive months of sobriety prior to graduation, and meet ACCSTP objectives. I understand my length of time in the Program is based on my individual needs and is determined, and adjusted, by the ACCSTP Program Team throughout my time in the Program. (___)

5. **GENERAL REQUIREMENTS:** I will attend all ACCSTP Court sessions and treatment sessions, submit to repeated drug screens, and address problems that contribute to my addiction, such as any underlying mental health issues I may have or criminal thinking. I understand that I must reduce risk factors for relapse and/or recidivism, which may include improving my family situation, bettering my employment status, increasing my educational level, and/or moving from known drug distributions areas. As a participant in the Program, I understand that will be required to pay restitution, participation fees, court fines, and/or other costs. I also understand that to continue in the Program, I must make suitable progress towards controlling my addiction and meeting Program requirements. (___)

6. **INDIVIDUALIZED TREATMENT PLANS:** The ACCSTP Treatment Team will set my individual treatment plan requirements, which will then be reviewed by the ACCSTP Program Team. I understand my treatment plan is subject to change, by increasing or decreasing, throughout the Program and is based on my ongoing treatment needs. (___)

7. **SELF-TERMINATION:** I may quit the Program at any time, but prior to that I must meet with the ACCSTP Judge and discuss my reasons for this decision with him/her, and he/she may delay my withdrawal from the Program for up to one (1) week to make sure my decision is firm I understand that if I quit the Program I will go back to court in front of the Judge who issued my original Sentencing Order, my probation may be revoked, and/or I may face imposition of the underlying terms of my sentence. Whether I am self-terminated from the Program, or involuntarily terminated from the Program, I understand that I cannot withdraw or change my plea on my underlying charges. (___)

8. **FEES:** I will be obligated to pay ACCSTP Seventy-Five Dollars ($75.00) per month as a participation fee, unless otherwise reduced by the ACCSTP Judge. I agree that I may also have to pay additional fees within the Program, which may include the costs of any electronic monitoring. Monies that I pay to ACCSTP are non-refundable. If I quit, am terminated, or if the Program ends for any reason, I will not get my money back. (___)

9. **SANCTIONS:** If I do not fully comply with ACCSTP requirements, the ACCSTP Judge may impose sanctions upon me at his/her sole discretion. I will have to complete the sanctions to continue in the Program and while a sanction is in place, I will not advance within the Program. Sanctions may include, but are not limited to, community service, a return to jail, electronic monitoring, phase regression, termination from the Program, or anything else deemed appropriate by the ACCSTP Judge. I understand that I do have the right to an evidentiary hearing to contest the imposition of sanctions. (___)

10. **RIGHT TO APPEAL:** I understand that the final decisions regarding my progress, compliance with ACCSTP requirements, and continued participation are in the Program are in the ACCSTP Judge's sole discretion and I have no right to appeal a decision of the ACCSTP Judge. (___)

11. **INCENTIVES:** If I meet certain Program requirements in a satisfactory manner, I may be eligible for an incentive. The use of incentives is designed to reward positive behaviors demonstrated by me and are awarded at the sole discretion of the ACCSTP Judge. Incentives may include, but are not limited to, gift certificates, fee waivers, and other items determined to be appropriate. (___)

12. **COURT PROCEEDINGS:** ACCSTP proceedings are informal and performed in open court. When in ACCSTP Court sessions, I will sit quietly with the other participants and observe the proceedings. I will wear appropriate dress for Court every time I am in Court. Appropriate dress includes clean clothes without

holes, dress shirt, blouse, polo shirt, button down shirt, pants, and dresses/skirts. Shoes will be worn at all times. I will not wear hats, sunglasses, T-shirts, shorts, clothing with slogans, etc. when in Court, nor will I chew gum or have food or drink in the Courtroom. I understand that my cell phone and all electronic devices must be turned off and failure to do so may result in sanctions. The ACCSTP Judge and Program Team will not tolerate disruptive behavior. I agree to treat the Court, ACCSTP Judge, ACCSTP Program Team, ACCSTP staff members, ACCSTP Treatment Team, and other participants with respect and courtesy. (___)

13. **SEARCHES:** As an ACCSTP Participant, I will submit to random searches of my person, vehicle, or residence for controlled substances, alcohol, paraphernalia, or other items that may violate the law or Probation and Parole or ACCSTP rules. I am aware that law enforcement officers and ACCSTP designees will be conducting random home visits and searches as part of my participation in the Program and when doing so are not acting as agents of Probation and Parole. As such, I understand that anything discovered during a search by a law enforcement officer as a result of my participation in the ACCSTP may be seized as evidence and used against me in court. I also acknowledge that I am subject to search of my person and property by my Treatment Provider, his/her staff, or designee while participating in treatment programming or while on Treatment Provider property. I understand that failure to comply with these search requirements may result in sanctions, including incarceration and/or termination from the Program. (___)

14. **RIGHT TO COUNSEL:** I understand that the ACCSTP Defense Counsel is not my personal attorney and does not individually represent my interests within the Program. I also understand that upon my entry into the Program my prior counsel may no longer be representing me, but I agree to continue in the Program with or without representation by counsel. However, I understand that I may hire a private attorney and/or talk to an attorney regarding my participation in the ACCSTP at any time during my participation in the Program. I understand that the ACCSTP is designed to be a non-adversarial forum with treatment and accountability being a primary focus. (___)

15. **WAIVER OF PRIVACY:** My participation in ACCSTP may require me to provide very personal information to ACCSTP Program Team members. This may include, but will not be limited to, my criminal record, substance abuse history, education, work history, family history, medical information, and mental health information. While Program staff and team members will try to avoid unnecessary embarrassment to me, I understand and agree that these things may be discussed in open ACCSTP court sessions, in treatment sessions, or in other settings related to my participation in the Program. I agree to promptly sign specific releases to allow the gathering, sharing, and dissemination of this information. (___)

16. **DUTY TO NOTIFY:** I must notify my Probation Agent and any other Program designee prior to any change in my residence or mailing address, any change or disconnection of my phone number, or any change in my employment. Additionally, while I am participating in the Program, and prior to making any purchases over $250.00 or entering into any new contracts, I will discuss those intended purchases and contracts with my Probation Agent. (___)

17. **POLICE CONTACT OR ARREST:** I must obey all laws and notify my Probation Agent immediately after any police contact or criminal charges made against me, including any driving violations or minor offenses. My arrest or conviction on other charges, or my failure to report other charges, may result in my termination from the Program. (___)

18. **VIOLENCE:** This Program is designed for non-violent persons, and I understand that no violence will be tolerated while I am in the Program. Any prior convictions I may have for violent felonies (per Wyoming Statute), or any other violent offense charges may make me ineligible for participation in the ACCSTP. Violent offenses may include charges that are not classified as violent under Wyoming law and will be reviewed by the Program on a case-by-case basis. I have disclosed to Program staff all my previous arrests and convictions. (___)

19. **NO ALCOHOL, ILLEGAL NARCOTICS, OR BANNED SUBSTANCES:** I understand that while I am in the Program, in addition to any other terms of my probation, I cannot drink, use, possess, or otherwise ingest alcohol, illegal narcotics, or banned substances, nor may I associate with those who do. I also understand that I am prohibited from entering any establishment where alcohol is sold as the primary source of revenue. I also may not use any substance that is now or may later be banned by the ACCSTP or my Probation Agent. This includes any medical or hygiene products that may contain alcohol, CBD, or other medicinal or synthetic products that may be abused, or are designed to mimic illegal substances, and understand that a positive test for these substances is subject to sanctions. (___)

20. **DILUTE SAMPLES:** I have been informed and understand that the ingestion of excessive amounts of fluids, among other things, can result in a dilute sample for drug testing purposes. Diluting, altering, or otherwise modifying or attempting to modify my body fluids in a way that alters, or attempts to alter, my drug test results will be considered tampering, treated as a positive result, and is subject to sanctions. I understand why dilute, altered, and/or tampered drug tests seriously compromise my recovery process. If I believe there is a medical reason for a dilute sample, it is my responsibility to provide the Program with a written opinion from my treating physician as to the underlying medical cause. (___)

21. **MEDICATIONS:** I understand that I will be required to provide frequent and random urine, blood, saliva, or other samples as a condition of my participation in the ACCSTP. I agree that I will not take any medications, including cough, cold, and any other over-the-counter medications, nor will I use alcohol-based mouthwash without prior approval from my Probation Agent or other ACCSTP designee. I further agree to not use or consume any food or beverage that contains poppy seeds or CBD while I am in the Program. I will also provide a complete list of medications I am prescribed and/or taking to my Probation Agent and sign any necessary releases of information for my Probation Agent to be able to monitor my medication management. I further agree to inform any and all providers I may see during my time in the Program of my substance use disorder history. (___)

22. **SEXUAL HARASSMENT POLICY:** It is the policy of the ACCSTP that all participants are entitled to an atmosphere that is free from any sexual harassment. Sexual harassment includes, but is not limited to, unwanted comments, gestures, writings, physical contact, and/or innuendo that is sexual in nature. I understand that if I sexually harass another participant, service provider, or ACCSTP staff or team member I will be subject to disciplinary review and could face severe consequences, including termination from the Program. (___)

23. **FRATERNIZATION:** I understand that ACCSTP policy requires that participants do not to engage in any romantic, dating, and/or sexual relationships with other Program participants. This type of fraternization is not conducive to a healthy treatment environment and will not be tolerated within the Program. Participants engaging in such relationships may be subject to sanctions and/or termination from the Program. (___)

24. **NO COMPROMISING AGENT SAFETY:** I understand that I may not share any information, verbally or otherwise, with other Program participants about the status or whereabouts of a Probation Agent or ACCSTP designee performing home compliance checks. Violation of this agreement rises to the level of a jail sanction. (___)

25. **WAIVER OF RIGHT TO REMAIN SILENT:** As a condition of my participation in ACCSTP, I am voluntarily giving up my right to remain silent and agree to participate fully and honestly in all ACCSTP meetings, treatment sessions, and ACCSTP Court sessions. (___)

26. **PHOTOGRAPH:** I agree to have my photograph made for ACCSTP files and in conjunction with Program activities. (____)

27. **LAW ENFORCEMENT NOTIFICATION:** I understand and agree that my participation in the Program will subject me to searches, home visits, schedule verification, and other actions as necessary by Laramie Police Officers, Albany County Sheriff Deputies, Probation Agents, and ACCSTP staff. My name, address, phone number, place of employment, and the names of persons I reside with will be shared with Officers and Deputies to help facilitate said duties. I understand and agree to cooperate fully with any and all lawful requests made to me by any Officer or Deputy, and I understand that my failure to comply could result in the Program imposing sanctions, including termination. I also understand that any information that I may disclose in treatment will not be shared with any law enforcement personnel except where disclosure is required by law. I understand that this waiver of notification is valid until my completion of the Program. (____)

28. **SUCCESSFUL COMPLETION:** Upon my successful completion of the Program, I understand I may request that my original sentencing Court modify my Sentence/Order to reduce my underlying terms and conditions of probation, penalties, and/or fines. However, I also understand the outcome of my request is at the sole discretion of the original sentencing Court Judge. (___)

My signature below indicates my full and complete understanding of the terms, conditions, and waivers within this document, my agreement to abide by said terms and conditions, and my voluntarily agreement to participate in the Program. I understand that my participation in the ACCSTP requires that I am waiving very important rights and that I had the opportunity to fully discuss my rights with an attorney before imposition of my underlying Sentence/Order that included my participation this Program as a term of my probation. I further acknowledge that at the time of executing this document my thinking is clear and I am not under the influence of any drugs or alcohol. I expressly agree to accept and abide by the terms and conditions of the ACCSTP as established herein or as may otherwise be established by the Program. (____)

_____ _____

Defendant/Participant Signature Date

_____

Defendant/Participant Printed Name

_____ _____

Witness Signature Date

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WYOMING DEPARTMENT OF CORRECTIONS
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Name:	Date of Birth: mm/dd/yyyy)	Social Security Number:

I request and authorize:

Name of person or organization making the disclosure: **Wyoming Department of Corrections**		
Address: **2020 Grand Avenue, Suite 390**		
City: **Laramie**	**State:** **WY**	**Zip Code:** **82070**
Telephone Number: **307-742-2451**	**Fax Number:** **307-742-7901**	

to ☒ disclose and/or ☒ receive to and/or from (check one or both boxes)

Name of person or organization to which disclosure is to be made**:** **Albany County Court Supervised Treatment Program**		
Address: **525 Grand Avenue, Suite 304**		
City: **Laramie**	**State:** **WY**	**Zip Code:** **82070**
Telephone Number: **307-721-1850**	**Fax Number:** **307-721-3089**	

The agencies listed above can release or disclose the following information:

Yes	Description
X	Assessment/evaluation reports
X	Diagnosis (if applicable)
X	Recommendations
X	Treatment or case plans
X	Meetings or sessions
X	My cooperation and follow through with recommendations
X	Prognosis
X	Other: **Supervision of probation**

The dates of records to be disclosed:

From: (mm/dd/yyy) 01/01/2021	To**:** (mm/dd/yyy) **End of Supervision**

I understand and approve that the information requested above can contain: (check all that apply)

X for Yes	Description
X	Information pertaining to drug and alcohol abuse, diagnosis and treatment (42 C.F.R. part 2).

X	Information regarding medical and mental health conditions, diagnosis and treatment (45 C.F.R. parts 160, 164)
X	Information concerning HIV and STD related test results and treatment
X	Information referencing academic achievement and testing including developmental disabilities (20 U.S.C. § 1232g; 34 CFR Part 99)
X	PSI to include release of juvenile criminal history records information.
X	Generic case information only.

The purpose of the disclosure authorized in this consent is to: (check all that apply)

X for Yes	**Description**
X	Facilitate the completion of a comprehensive assessment.
X	Provide information necessary for referral and/or joint case management.
X	Provide information necessary for outcomes tracking and follow up.
☐	Other: (Note, probation and parole records are privileged per statute and may only be released to authorized entities)

I understand that my alcohol and /or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

End of Supervision

(Specific date, condition or event upon which this consent expires)

If the above information contains information concerning alcohol or drug assessment and treatment this consent is made upon the promise that all disclosures made pursuant to the authority granted by this consent will be accompanied by a written notice which states as follows, to wit:

> "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose".

In the event that an oral disclosure is made pursuant to this consent, then said oral disclosure shall be accompanied by or followed by such a notice.

I have read the above and foregoing CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION and I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent. I verify that all blanks requiring insertion were before I signed.

I authorize the use and/or release of my protected health information as described above and understand this authorization is voluntary and is made to confirm my request. I further understand that if the organization or person authorized to receive the information is not a covered health care or substance abuse provider the information may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.

By my signature below, I acknowledge approval for the release of the information contained in the check boxes above and for the purposes indicted by the boxes checked.

Signature of individual authorizing this Consent:		**Date: (mm/dd/yyyy)**	
Signature of witness:		**Date: (mm/dd/yyyy)**	
Signature of legally responsible person:		**Date: (mm/dd/yyyy)**	
Specify relationship:		**Telephone Number:**	
Address	City:	**State:**	**Zip Code:**

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

NAME:	Date of Birth:	Social Security Number:

I request and authorize Foundations Counseling & Consulting of Wyoming to:

☒Disclose and/or ☒Receive to and/or from

Name of Person or organization**: Albany County Court Supervised Treatment Program**		
Address: 525 Grand Ave., Suite 304		
City: Laramie	State: WY	Zip: 82070
Telephone Number 307-721-1850	Fax Number 307-721-3089	

The Date of records to be disclosed

From: Application date	**To: The end of my participation**

I understand and approve that the information requested can contain: (Check all that apply)

☒Attendance Records ☒Medical Diagnosis ☒Academic Records

☒Clinical Assessments ☒Progress in Treatment ☒Consultation

☒Police & Court Records ☒Medical Records ☒Explanation of Incident

☐Payment Records ☒Psychiatric Diagnosis ☒Medical Injury/Illness

☒Mental Health Records ☒UA/BA results ☒Inability to Drive

☐Other Explain _____ _____

For the purpose of the disclosure authorized in this consent is to:

☒Coordination of Treatment ☐Evaluation ☐Illness/Injury/Emergency Transportation

☐Other Explain _____ _____

I understand that my treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **One year from the date of signature**

_____ _____

Signature of Individual authorizing this Consent: Date:

ALBANY COUNTY COURT SUPERVISED TREATMENT PROGRAM

525 Grand Avenue, Suite 304
Phone: 307-721-1850
Fax: 307-721-3089

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (DOB: _____/ _____/_____) do hereby release the following records and/or information described below to be exchanged between ACCSTP and the listed organization. My authorization to release includes the categories I have ***initialed.*** I understand that I may revoke/withdraw this authorization at any time, in writing or verbally, except to the extent that action has been taken. I will deliver my revocation/withdrawal to ACCSTP at 525 Grand Avenue Suite 304, Laramie, Wyoming 82070. I understand I am giving this authorization in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

ACCSTP:	Organization:
Albany County Court Supervised Treatment Program **525 Grand Avenue, Suite 304** **Laramie, WY 82070** **307-721-1850**	**Department of Corrections** **2020 Grand Avenue, Suite 390** **Laramie, WY 82070** **307-742-2451**

The dates of records to be disclosed:

From: Application Date	**To: The end of my participation in the program**

I understand that this release will include information I **initialed** below, and I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____Assessment Information / Results **_____Verbal Communications**
_____Treatment Recommendations **_____Treatment Progress**
_____Summary of Substance evaluation **_____Medication History**
_____Laboratory/Drug Screen Reports **_____Discharge Summary**
_____Treatment recommendations and compliance **_____Diagnosis**
_____Other: Information related the collection and/or witnessing of results of urinalysis testing.

This information may be transmitted by mail, by fax, in person or verbally. The purpose/need of this request is:
__X__ Continuity of Care __X__ Legal Matter __X__ Insurance Claim __X__ Personal __X__ Other: joint case management

This authorization will remain in effect until termination from ACCSTP unless otherwise revoked or withdrawn by Client. I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without my specific written consent. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosures expressly permitted by the written consent of the persons to whom it pertains or as otherwise permitted by 42 CFR PART 2. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ Date: _____
Signature of Client (or person authorized to sign for client)

_____ Relationship: _____
Print Name of Client (or person authorized to sign)

_____
Signature of Witness

_____ Date: _____
Print Name of Witness

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ALBANY COUNTY COURT SUPERVISED TREATMENT PROGRAM

525 Grand Avenue, Suite 304
Phone: 307-721-1850
Fax: 307-721-3089

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (DOB: _____/ _____/_____) do hereby release the following records and/or information described below to be exchanged between ACCSTP and the listed organization. My authorization to release includes the categories I have ***initialed.*** I understand that I may revoke/withdraw this authorization at any time, in writing or verbally, except to the extent that action has been taken. I will deliver my revocation/withdrawal to ACCSTP at 525 Grand Avenue Suite 304, Laramie, Wyoming 82070. I understand I am giving this authorization in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

ACCSTP:	Organization:
Albany County Court Supervised Treatment Program **525 Grand Avenue, Suite 304** **Laramie, WY 82070** **307-721-1850**	**Grand Avenue Urgent Care** **3236 Grand Avenue** **Laramie, WY 82070** **307-760-8602**

The dates of records to be disclosed:

From: Application Date	**To: The end of my participation in the program**

I understand that this release will include information I **initialed** below, and I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____Assessment Information / Results **_____Verbal Communications**
_____Treatment Recommendations **_____Treatment Progress**
_____Summary of Substance evaluation **_____Medication History**
_____Laboratory/Drug Screen Reports **_____Discharge Summary**
_____Treatment recommendations and compliance **_____Diagnosis**
_____Other: Information related the collection and/or witnessing of results of urinalysis testing.

This information may be transmitted by mail, by fax, in person or verbally. The purpose/need of this request is:
__X__Continuity of Care __X__Legal Matter __X__ Insurance Claim __X__Personal __X__Other: joint case management

This authorization will remain in effect until termination from ACCSTP unless otherwise revoked or withdrawn by Client. I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without my specific written consent. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosures expressly permitted by the written consent of the persons to whom it pertains or as otherwise permitted by 42 CFR PART 2. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ Date: _____
Signature of Client (or person authorized to sign for client)

_____ Relationship: _____
Print Name of Client (or person authorized to sign)

_____
Signature of Witness

_____ Date: _____
Print Name of Witness

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ALBANY COUNTY COURT SUPERVISED TREATMENT PROGRAM

525 Grand Avenue, Suite 304
Phone: 307-721-1850
Fax: 307-721-3089

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (DOB: _____/ _____/_____) do hereby release the following records and/or information described below to be exchanged between ACCSTP and the listed organization. My authorization to release includes the categories I have ***initialed.*** I understand that I may revoke/withdraw this authorization at any time, in writing or verbally, except to the extent that action has been taken. I will deliver my revocation/withdrawal to ACCSTP at 525 Grand Avenue Suite 304, Laramie, Wyoming 82070. I understand I am giving this authorization in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

ACCSTP:	Organization:
Albany County Court Supervised Treatment Program **525 Grand Avenue, Suite 304** **Laramie, WY 82070** **307-721-1850**	**Foundations** **515 East Carlson, Suite 104** **Cheyenne, WY 82009** **307-638-4092**

The dates of records to be disclosed:

From: Application Date	**To: The end of my participation in the program**

I understand that this release will include information I **initialed** below, and I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____Assessment Information / Results **_____Verbal Communications**
_____Treatment Recommendations **_____Treatment Progress**
_____Summary of Substance evaluation **_____Medication History**
_____Laboratory/Drug Screen Reports **_____Discharge Summary**
_____Treatment recommendations and compliance **_____Diagnosis**
_____Other: Information related the collection and/or witnessing of results of urinalysis testing.

This information may be transmitted by mail, by fax, in person or verbally. The purpose/need of this request is:
__X__Continuity of Care __X__Legal Matter __X__ Insurance Claim __X__Personal __X__Other: joint case management

This authorization will remain in effect until termination from ACCSTP unless otherwise revoked or withdrawn by Client. I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without my specific written consent. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosures expressly permitted by the written consent of the persons to whom it pertains or as otherwise permitted by 42 CFR PART 2. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ Date: _____
Signature of Client (or person authorized to sign for client)

_____ Relationship: _____
Print Name of Client (or person authorized to sign)

_____
Signature of Witness

_____ Date: _____
Print Name of Witness

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ALBANY COUNTY COURT SUPERVISED TREATMENT PROGRAM

525 Grand Avenue, Suite 304
Phone: 307-721-1850
Fax: 307-721-3089

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (DOB: _____/ _____/_____) do hereby release the following records and/or information described below to be exchanged between ACCSTP and the listed organization. My authorization to release includes the categories I have ***initialed.*** I understand that I may revoke/withdraw this authorization at any time, in writing or verbally, except to the extent that action has been taken. I will deliver my revocation/withdrawal to ACCSTP at 525 Grand Avenue Suite 304, Laramie, Wyoming 82070. I understand I am giving this authorization in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

ACCSTP:	Organization:
Albany County Court Supervised Treatment Program (ACCSTP) **525 Grand Avenue, Suite 304** **Laramie, WY 82070**	**Albany Community Health Clinic** **1174 22nd St.** **Laramie, WY 82072** **307-766-3313**

The dates of records to be disclosed:

From: Application Date	**To: The end of my participation in the program**

I understand that this release will include information I **initialed** below, and I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____Assessment Information / Results **_____Verbal Communications**
_____Treatment Recommendations **_____Treatment Progress**
_____Summary of Substance evaluation **_____Medication History**
_____Laboratory/Drug Screen Reports **_____Discharge Summary**
_____Treatment recommendations and compliance **_____Diagnosis**
_____Other: Information related the collection and/or witnessing of results of urinalysis testing.

This information may be transmitted by mail, by fax, in person or verbally. The purpose/need of this request is:
_x_ Continuity of Care _x_ Legal Matter _x_ Insurance Claim _x_ Personal _x_ Other: Joint Case Management

This authorization will remain in effect until termination from ACCSTP unless otherwise revoked or withdrawn by Client. I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without my specific written consent. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosures expressly permitted by the written consent of the persons to whom it pertains or as otherwise permitted by 42 CFR PART 2. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ Date: _____
Signature of Client (or person authorized to sign for client)

_____ Relationship: _____
Print Name of Client (or person authorized to sign)

_____
Signature of Witness

_____ Date: _____
Print Name of Witness