Eastern Missouri Alternative Sentencing Services, Inc.

|  |  |  |
| --- | --- | --- |
|  | **RELEASE OF INFORMATION** |  |

I,, DOB  do hereby authorize Eastern Missouri Alternative Sentencing Services, Inc. (E.M.A.S.S.) to release/obtain to:

|  |  |  |  |
| --- | --- | --- | --- |
| Attorney |   | Probation Officer |   |
| Courts |   | Emergency Contact |   |
| Others |   |

The following information regarding

* My assessment recommendation, my status in treatment, and my completion of my S.A.T.O.P. assignment.
* 

 (other)

The purpose of disclosure is to:

* Keep my referral source apprised of my status in the S.A.T.O.P., assist in facilitating interventions in emergency situations, and facilitate my court case or reinstatement of my driving privileges.
* 

 (other)

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate 1 year from signing or on the following date.

 (Specify date, event, or condition)

 

 (signature of client or legal guardian) (date)

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

 (Staff signature) (date)

|  |
| --- |
| This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. |