



Citizen Circle Referral

DEMOGRAPHIC INFORMATION				Date:	
First Name:				Last Name:	
Address:					
City:			County:		
Phone or Contact Number:					
Date of Birth:		Race:		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Release Date:		Release Type:		Institution:	
Number:					
What Areas do You Need help? (check all that apply)					
Employment: <i>Work and the role of work in the person's life.</i> <input type="checkbox"/> Resume Writing <input type="checkbox"/> Interviewing Skills					<input type="checkbox"/>
Education: <i>Education and vocational skills wanted.</i> <input type="checkbox"/> GED <input type="checkbox"/> Vocational Training <input type="checkbox"/> College					<input type="checkbox"/>
Marital/Family: <i>Being with family members and the support from them.</i> <input type="checkbox"/> Counseling <input type="checkbox"/> Childcare <input type="checkbox"/> Child Support <input type="checkbox"/> Parenting Classes					<input type="checkbox"/>
Associates: <i>Positive interaction with peers.</i> <input type="checkbox"/> Mentoring					<input type="checkbox"/>
Substance Abuse: <i>Living without reliance on alcohol and/or other drugs.</i> <input type="checkbox"/> AA/NA/CA <input type="checkbox"/> Substance Abuse Counseling <input type="checkbox"/> Residential Treatment					<input type="checkbox"/>
Community Functioning: <i>Knowledge and skills for daily living.</i> <input type="checkbox"/> Housing <input type="checkbox"/> Medical <input type="checkbox"/> Budgeting <input type="checkbox"/> Transportation/Driver's License <input type="checkbox"/> Leisure Activities					<input type="checkbox"/>
Personal/Emotional: <i>Practicing mental health and wellness activities.</i> <input type="checkbox"/> Mental Health Referral <input type="checkbox"/> Sex Offender Treatment					<input type="checkbox"/>
Attitude: <i>Supporting law-abiding behaviors and involvement with religious activities.</i> <input type="checkbox"/> Pending Legal Issues <input type="checkbox"/> Faith-Based Involvement					<input type="checkbox"/>
Other:					<input type="checkbox"/>
What can the Circle do to help you?					
Signature of Participant				Date	
Signature of Circle Representative				Date	

**CITIZEN CIRCLE
AUTHORIZATION FOR INFORMATION SHARING**

Last First Middle Date of Birth

I authorize CITIZEN CIRCLE members to exchange, give, receive, share or disclose information in their records, from whatever source derived, and related to my participation.

I authorize the release of the identified confidential information to members of the CITIZEN CIRCLE. (Please check Yes and initial for all those that apply).

- Yes _____ Ohio Department of Rehabilitation and Correction
- Yes _____ Local Law Enforcement
- Yes _____ Other _____
- Yes _____ Other _____
- Yes _____ Other _____

I understand the following:

1. The purpose of this information sharing is to improve communications between Circle members and me, so that proper suggested services and referrals can be given.
2. I may revoke this Authorization at any time during the duration of this agreement.
3. Only members of the Circle will use information disclosed. However, I understand that disclosure of information in Circle meetings can and will be used in monitoring compliance with sobriety and release conditions agreed to, or ordered by affiliate agencies or authorities. I further understand that affiliate agencies or authorities have the right to adjust services or provide sanctions in response to information disclosed at the Circle meetings.
4. Future crimes or threats to commit crime are not protected under this authorization.
5. Suspicion of child abuse or neglect is not protected.
6. Non-identifying information from the referral form and project will be used for research and evaluation purposes by Dr. Morris Jenkins, the staff at the University of Toledo, and the Ohio Department of Rehabilitation and Correction.
7. This authorization will automatically expire on _____.

I authorize the release of the following information: (Please check "Yes" and initial for all those that apply).

- Yes _____ Substance Abuse diagnosis and treatment information
- Yes _____ Criminal history
- Yes _____ Medical and mental health history
- Yes _____ Educational, vocational, and employment records
- Yes _____ Attendance records, progress reports
- Yes _____ Other _____
- Yes _____ Other _____

I also understand that any disclosure is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of drug and alcohol abuse patient records. These rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Executed this date: _____ Participant: _____

Witness: _____

CONFIDENTIAL CLIENT INFORMATION--ANY UNAUTHORIZED DISCLOSURE IS A STATE OF OHIO AND FEDERAL OFFENSE