IN THE MUNICIPAL COURT OF THE CITY OF HERMISTON
UMATILLA COUNTY, OREGON
180 NE 2nd St., Hermiston, OR 97838

STATE OF OREGON	Case No. ____________________
Plaintiff	**TREATMENT PROVIDER SELECTION AGREEMENT AND HIPAA WAIVER**
v.	☐ Pre-Trial Release- Conditional Release
____________________	☐ Diversion/Cond. Discharge
Defendant	☐ Conviction- Probation Requirement
DOB: ____________________	☐ Re-Referral or Provider Change

DEFENDANT: YOU MUST READ AND COMPLY WITH THE FOLLOWING INSTRUCTIONS:

You are subject to the requirements of diversion or probation (see Diversion or Judgment and Sentence Order). Your compliance is required and time sensitive.

- Contact the selected providers, schedule your appointments, and complete any evaluations within 30 days from today or your release from jail, whichever is later. You cannot change evaluators without written permission of the court.
- Take all of your court orders/judgments and this agreement to the provider along with any treatment records.
- File written proof including your name and case numbers with the court as soon as you have enrolled but no later than 30 days from the date the judgment or order of the court is signed. You must **ALSO** file proof of completion. If you have not completed the program within 6 months, you must file status updates with the court every 6 months until completion. A sample Notice of Compliance form is available from the court.
- Your signature on this form authorizes the treatment provider to release Protected Health Information under a federal law known as 'HIPAA.'
- If you fail to start, pay for or complete treatment, the provider will report any non-compliance to the court, and you will then receive an Order to Show Cause to appear in court to show cause why your diversion or probation should not be revoked. If you fail to appear for the Show Cause hearing, a warrant will likely issue for your arrest and there may be further charge or adverse consequences to you for failing to appear.

TREATMENT PROVIDER LOCATION AND CONTACT INFORMATION

Community Counseling Solutions		
104 SW Kinkade Ave / PO Box 261	Boardman, OR 97818	541-481-2911
435 E Newport Ave. STE A	Hermiston, OR 97838	541-564-9390 A&D
595 NW 11th St.	Hermiston, OR 97838	541-567-2536 MH
211 SW 1st St.	Pendleton, OR 97801	541-278-6330 A&D
331 SW 2nd St.	Pendleton, OR 97801	541-276-6207 MH
OWhN/COPES Outpatient		
200 SE Hailey Ave STE 204	Pendleton, OR 97801	541-663-4104
New Horizons		
440 SW 11th St.	Hermiston, OR 97838	541-289-0190
Eastern Oregon Recovery Center		
216 SW Hailey Ave	Pendleton, OR 97801	541-276-3518 ext 204

Docket #: _______________

☐ **ALCOHOL/DRUG SCREENING & ASSESSMENT (other than DUII):**
☐ Community Counseling ☐ OWHN/COPES OUTPATIENT ☐ New Horizons

☐ **ANGER MANAGEMENT:**
☐ Community Counseling ☐ New Horizons

☐ **DUII & DIVERSION DRUG/ALCOHOL SCREENING AND ASSESMENTS (ADES):** BAC _____
☐ Eastern Oregon Recovery Center

☐ **MENTAL HEALTH:**
☐ Community Counseling

☐ **THEFT COUNSELING:**
☐ Community Counseling ☐ New Horizons

PATIENT CONSENT: I authorize the providers marked above to disclose my private health information as identified below to the Hermiston Municipal Court for the State of Oregon City of Hermiston. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to each provider. However, any refusal to sign or any subsequent revocation of my consent may violate the conditions of my diversion or probation. I may inspect or copy any information disclosed under this authorization. Unless revoked earlier, this authorization will terminate upon the filing of a notice of compliance indicating successful completion of treatment, or termination of diversion or probation. I understand the purpose of this consent is to allow the court, the city prosecutor, and my attorney to determine my compliance with the conditions of diversion or probation. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy authorizing to disclose my information may receive compensation for doing so.

Disclosure shall include: Attendance or non-attendance at evaluation; assessment and recommended treatment; brief description of recommended treatment, compliance or non-compliance with recommended treatment to include compliance or non-compliance with prescribed medications, certification of treatment, failure to complete treatment, failure to pay as required; and discharge summary. I hereby declare that the above statement is true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury.

________________ ____
Date Signature

____
Address, City, State, Zip Phone (REQUIRED)

Acknowledged & Accepted by Judge:____