



Catholic Social Services of Washtenaw County
 Alternatives to Domestic Aggression
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REFERRAL TO ADA
Reciprocal Release of Information Authorization

1. Referral Information (to be completed by the referring agency):

Date: ___/___/___ Date of Offense: ___/___/___ Probation Term: _____
 Full Name: _____
 Charge(s): _____
 Date of Birth: ___/___/___
 Street Address: _____ City: _____ Zip Code: _____
 Home Phone: () _____ - _____ Other Phone: () _____ - _____

2. Referral Source: Criminal Justice (*see below*) Therapist F.I.A. Other: _____

Name: _____ Phone: () _____ - _____
 Address: _____
 Pertinent Information: _____

Criminal Justice System Referral Source Only:

Referring Agency and/or Person(s) Name: _____
 Title: Probation Officer Parole Officer Judge Magistrate
 District Court: _____ Circuit Court: _____ Juvenile Court
 Court Case Number: _____ Sentencing Date: ___/___/___
 Intensive Probation Probation Deferred Sentence Delayed Sentence Bench Referral

Pertinent Information: _____

 Prior Convictions: _____

3. Program Referred To:

Alternatives to Domestic Aggression **Shedding Some Light**

4. Release Authorization (to be signed by the person being referred):

In signing this release I understand that I give permission for all parties listed on this form, designee, records department, successors, assigns and any personnel necessary to the performance of the duties of the individual and/or agency, to release information in my records regarding medical, psychological, emotional, psychiatric, alcohol, or drug treatment or history, diagnosis, prognosis, assessment, intervention(s), attendance, services rendered, recommendations, progress, medication, treatment plans, summaries, sickle cell anemia, sexually transmitted diseases, TB, Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS Related Complex (ARC), if any. The purpose of this disclosure is to assist this agency and/or persons in arriving at an equitable and appropriate disposition of my case. This authorization will remain in effect until 365 days following my discharge from services at ADA. 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.

_____/_____/_____
 Service Participant Signature Date Witness Signature Date