



**Scarborough Police Department  
Operation HOPE  
Program Participant Agreement**

This is to certify that I, (participant name) \_\_\_\_\_, agree to allow a Volunteer ANGEL to accompany and assist me during my intake.

I also agree to be contacted in the future by the Scarborough Police Department Operation HOPE, Police Assisted Addiction Recovery Initiative and/or the Portland Recovery Community Center to learn about my experience in the program. I understand that the information I provide may be used by the Scarborough Police Department Operation HOPE, the Police Assisted Addiction Recovery Initiative and/or the Portland Recovery Community Center to help improve the program. My name will not be used.

I agree that if there is any exchange of contact information (phone numbers, email addresses, physical addresses, etc.) with the ANGEL, this will be done only with mutual agreement between the participant and the ANGEL.

I further agree that any scheduled contact with the ANGEL outside of the Scarborough Police Department and/or Operation HOPE is a personal decision and will not be inclusive in any part of the Operation HOPE program.

I also agree to allow any and all treatment centers to update the Scarborough Police Department Operation HOPE, the Police Assisted Addiction Recovery Initiative and/or the Portland Recovery Community Center on the status of my treatment and related issues, specifically: Whether I successfully completed the treatment program; Dates of treatment, and Discharge status. This is done purely for statistical reasons and will be used for follow up on the program. These updates will be secure and strictly confidential.

I understand that my alcohol and/or drug abuse treatment records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke this consent orally or in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate one year from execution of this agreement:

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**NOTICE TO RECIPIENT OF INFORMATION**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.



**NOTE:** Upon completion of form, officer will provide a copy to the Operation HOPE "Angel" assigned to work with participant and attach original to the associated OF.