

Defendant Application Questionnaire

Name: _____ Date: _____

This form should be filled out by the Mental Health Court applicant. In order for the Mental Health Court Judge and Team to determine whether or not you are eligible for Mental Health Court, we need you to give us some information about your history. **Please circle "Yes" or "No" after each question. If the question asks for an answer, do your best to answer it.** If you need more room, please use the back of this form. If you have any questions, call the Mental Health Court at 208-287-7507. **Remember, there are no right or wrong answers!**

- 1. Do you have a mental illness? **Yes** **No**
- 2. Do you live in Ada County? **Yes** **No**
- 3. If you do not live in Ada County, are you planning to move to Ada County? **Yes** **No**
- 4. If you live or plan to live in Ada County, please tell us **exactly where** you will live, **who** you will live with, and **when** you will start living there: _____

- 5. What is your mental illness (diagnosis)? _____
- 6. Who diagnosed your illness? _____
- 7. Are you currently being treated for your mental illness? **Yes** **No**
- 8. Where do you receive treatment for your mental illness? _____
- 9. What medications do you take for your mental illness? _____

- 10. Do you have any substance abuse or addiction issues? **Yes** **No**
(NOTE: Having a substance abuse problem doesn't stop you from being eligible.)
- 11. Have you ever suffered from a traumatic brain injury? **Yes** **No**
- 12. Do you have a learning disability or are you developmentally delayed? **Yes** **No**
(You may still be eligible for Mental Health Court, but this information is important for the team to have.)
- 13. Are you required to register as a sex offender? **Yes** **No**
- 14. Have you been prosecuted for any violent crimes? **Yes** **No**
- 15. Please list all crimes **you have been prosecuted for** in the past: _____

- 16. Have you ever been on probation? **Yes** **No**
- 17. If yes, in what county and who was your P.O.? _____
- 18. If you have children, please list their names, ages, and who takes care of them: _____

- 19. Why do you want to be in the Mental Health Court? _____

**IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE
STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA**

STATE OF IDAHO

Plaintiff,

vs.

Defendant.

Case No. _____

**APPLICATION TO PARTICIPATE IN THE
ADA COUNTY FELONY MENTAL HEALTH
COURT**

I hereby apply for admission into the Ada County Felony Mental Health Court Program. I have read the Ada County Felony Mental Health Court Program handbook. I acknowledge that, as part of the application process:

- a. My prior criminal record, if any, will be reviewed to determine whether I am eligible to participate in Ada County Felony Mental Health Court Program.
- b. I will be required to complete a Level of Service Inventory-Revised evaluation.
- c. I will be required to complete an alcohol/drug screening by an approved treatment provider.
- d. I will be required to complete a diagnosis/evaluation by the Mental Health Court Coordinator and/or Idaho Dept. of Health and Welfare Region IV Mental Health.
- e. My application, my prior record, the results of the LSI-R, the results of the alcohol/drug screening, and the results of my diagnosis/evaluation will be reviewed by a Mental Health Court team. Admission into the Ada County Felony Mental Health Court Program will be at the sole discretion of the Mental Health Court team.

IF ACCEPTED INTO THE ADA COUNTY FELONY MENTAL HEALTH COURT PROGRAM, I AGREE TO COMPLY WITH THE FOLLOWING CONDITIONS OF ADMISSION:

1. I will comply with all requirements contained in the Ada County Mental Health Court Program handbook.
2. I will sign a probation agreement with the State of Idaho Department of Probation and Parole or the Ada County Department of Probation and fully comply with all requirements of probation.
3. I will authorize release of all treatment information to the Mental Health Court team which may include, but not be limited to, my attorney, the prosecuting attorney, the Mental Health Court judge, a representative of probation and parole, the Department of Health and Welfare, and other Mental Health Court team members and treatment providers. This information may be used by the Mental Health Court team to determine my level of participation in and compliance with the Mental Health Court program, to modify my release conditions and/or to decide to terminate my participation in the program. The information may also be used to modify or terminate probation. The

information will not be used by the prosecuting attorney for the prosecution of any new crime.

4. I will appear in court for all scheduled hearings.

I understand that any failure on my part to comply with the Ada County Felony Mental Health Court Program requirements may result in modification or revocation of my probation, including the imposition of sentence.

DATED this _____ day of _____, 2009.

Defendant's Signature

Date of Birth

Social Security Number

This application must be submitted to the Ada County Felony Mental Health Court Coordinator.

Fax: 287-7549

**IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE
STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA**

STATE OF IDAHO

Plaintiff,

vs.

Defendant.

Case No. _____

**CONSENT FOR DISCLOSURE OF
CONFIDENTIAL MENTAL HEALTH AND
SUBSTANCE ABUSE INFORMATION**

I, _____, hereby give my permission for an open exchange of information among provider(s) of the members of the Ada County Mental Health Court team, including:

- Ada County Mental Health Court Presiding Judge,
- Ada County Prosecuting Attorney or Deputy Attorney,
- Ada County Public Defender or other Defense Counsel,
- Forensic Assertive Community Treatment (FACT) Team, Idaho Department of Health and Welfare, Region IV, and collateral IDHW staff as appropriate,
- Idaho Department of Corrections, District IV Community Corrections Staff,
- Idaho Department of Corrections, Pre-Sentence Investigators,
- Ada County Mental Health Court Coordinator and other Staff,
- Ascent Behavioral Health Services and its staff,
- Ada County Sheriff's Department,
- Idaho Division of Vocational Rehabilitation,
- Other education, vocational, medical or health providers or agencies, providing services to the Ada County Mental Health Court participants,
- Local law enforcement agencies, but only as such information is needed for monitoring my case and compliance with mental health court conditions of participation,
- Ada County Drug Court Treatment Services Center, for drug testing purposes, if required to drug test at this location.
- Advanced Drug Detection, for drug testing purposes, if required to drug test at this location.
- _____(Housing provider),
- In appropriate circumstances, the "victim," _____,

And _____ Relationship _____
Name of Person

And _____ Relationship _____
Name of Person

And _____ Relationship _____
Name of Person

The purpose of, and need for, this disclosure and exchange of information is to provide information about my eligibility and/or acceptability for Mental Health Court and about the nature of the substance abuse treatment services I need. The information to be exchanged may include information about my diagnosis, treatment plan, treatment attendance, program compliance, progress, and prognosis, as this information relates to the Mental Health Court conditions of each phase of participation and progress monitoring criteria. This information will allow the team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior, to submit billings for services, to audit, evaluate, or conduct legitimate research about Mental Health Court activities and effectiveness, and will also allow any persons named in this consent (such as family members) to be involved in my Mental Health Court activities. I further understand that some or all of this information will be discussed in **open court**, where any person in the courtroom may hear the information. The nature of the information to be shared will include, but is not limited to: arrest and prior criminal record, intake and pre-sentence investigation report information, risk and alcohol/drug use assessment and diagnosis information, treatment plans, court directives, drug test results, progress reports, program compliance and other related behavior, and recommendations for services, sanctions and rewards.

Disclosure of this otherwise confidential information may be made only as necessary for, and pertinent to, hearings, case planning, and/or reports concerning Case No._____. No person, other than as listed above, will have access to this information without my further consent.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Mental Health Court for the above referenced case, either by my successful completion of the Mental Health Court requirements OR upon sentencing for violating the terms of my Mental Health Court involvement. I agree that the release of the above information, prior to Mental Health Court termination and/or sentencing, shall not be a breach of my right to confidentiality.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (42 CFR, part 2), which governs the confidentiality of substance abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties and only with respect to these particular criminal proceedings.

Date

Defendant Printed Name

Defendant Signature

Witness Signature

Title

Signature of Interpreter (where applicable)

**IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE
STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA**

STATE OF IDAHO

Plaintiff,

vs.

Defendant.

Case No. _____

**AUTHORIZATION FOR DISCLOSURE OF
CONFIDENTIAL SUBSTANCE ABUSE
INFORMATION**

I, _____, hereby authorize disclosure of all information regarding my diagnosis, prognosis and treatment by _____ (treatment provider) to the Ada County Felony Mental Health Court Program team. The team includes, but may not be limited to the Judge presiding over the Ada County Felony Mental Health Court Program, the Mental Health Court Administrator, the prosecuting attorney, my personal attorney whether privately retained or a public defender, officers from the probation department in the particular county where my case is being handled, a representative from the Idaho Department of Health and Welfare, and a representative of the treatment provider.

The purpose of and need for this disclosure is to inform the Mental Health Court and the Mental Health Court team members of my eligibility and/or acceptability for substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the Mental Health Court monitoring criteria.

Disclosure of this confidential information may be made only as necessary for and pertinent to hearings and/or reports concerning this case.

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. I understand that

revocation of this consent will result in termination of my participation with Mental Health Court.
If not previously revoked, this consent will terminate upon completion of my probation.

I understand that any disclosure made is bound by federal law, specifically Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse and mental health patient and/or client records, and the recipients of this information may re-disclose it only in connection with their official duties.

Dated _____

_____ Defendant

MENTAL HEALTH COURT DEFENDANT INFORMATION SHEET

Today's Date

Defendant's Name

First

Middle

Last

AKAs (Also Known As)

Phone Number

- Home
 Cell
 Message

Address

Street (no Post Office boxes)

Apt/Space Number

City

State

Zip Code

Social Security No.

Birthday

Driver's License No.

Identification Number

Issuing State

Employer Name

Phone No.

Address

Street (no Post Office boxes)

City

Zip

Main Vehicle

License Plate No.

Year

Make

Model

2 door/4 door

Secondary Vehicle

License Plate No.

Year

Make

Model

2 door/4 door

MESSAGE and/or EMERGENCY CONTACT

Name

Address

Phone No.

Relationship to you

GENERAL PHYSICAL DESCRIPTION

Male

Female

Height

Feet

Inches

Weight

Pounds

Hair Color

Eye Color

Other Language

Spanish

Sign

Other, specify:

Ada County Mental Health Court

List of Mental Health Care Providers

The main criteria for acceptance in the Ada County Mental Health Court is having a severe and persistent mental illness. In order to screen you for Mental Health Court, we need to collect records from **mental health** providers who can verify your **mental health** treatment and diagnostic history. Please fill out the form below with as much information as you can. We will ask you to sign release forms for each treatment provider so that we can help you collect medical records to support your application.

Defendant: _____

Date: _____

Provider Name (Please include phone number and address information if you know it.)	City, State	Dates of Treatment (What month/year did you start seeing this provider, and when did you stop seeing them?)

If you need more room, please use the back of this form.

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form along with your other MHC Paperwork.

Client Information

Client Name _____ Date of Birth _____ Telephone _____
(First, MI, Last)

Mailing Address _____ State _____ Zip Code _____

Requestor Information

(To be completed if authorization is being made by someone other than the subject of the information, please provide documentation of your authority.)

Requestor Name (If different than client) _____ Telephone _____

Mailing Address _____ State _____ Zip Code _____

Authorization Details

I authorize the following Individual, organization or business _____

To disclose my confidential information to: Region 4 FACT Team

Address 1720 Westgate Dr. State ID Zip Code 83704 for the purpose of
Evaluation & Assessment.

Please describe in detail the information to be disclosed Assessments, Doctor Evaluations, etc.

This authorization will expire in six months unless another date or event is specified here _____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare office. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your signature: _____ Date: _____

Your signature must be notarized if we are unable to verify your identity and you submit this request by mail.

INTERMOUNTAIN HOSPITAL

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize: Intermountain Hospital
303 N. Allumbaugh
Boise, ID 83704
(208) 377-8400

To use or release health information and records obtained during the course of treatment of:

Patient Name: _____ Date of Birth: _____
Address: _____ Patient's Phone: _____
_____ Social Security No.: _____
_____ Date of Death: _____

1. The information is to be used or disclosed to the following persons or organizations:

Person/Entity Name: Ada County Mental Health Court
Address: 200 W. Front Street, Rm. 505A, Boise, ID 83702-7300
Phone: 208-287-7507

2. Purpose: The purpose of the use or disclosure is:

- ~ At the request of the patient
- ~ Other: _____

3. Information to be used or disclosed:

The information to be used or disclosed includes only those items checked below, with respect to services provided on or around (insert dates of service): January, 2004. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge and claims resolution.

I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

- Discharge Summary
- Psychiatric Evaluation
- Treatment Plans
- X-Ray Reports
- Laboratory Data
- Consultation Reports
- History and Physical Exam
- Psychological Testing
- Physician Progress Notes
- Staff Progress Notes
- Medication Records
- Verbal Communication with:

<input checked="" type="checkbox"/> Assessments	_____ Name
<input checked="" type="checkbox"/> Billing/Financial Records	_____ Relationship
<input checked="" type="checkbox"/> Other	_____ Verbal Communication with:
<input checked="" type="checkbox"/> Letter with date and physician name	_____ Name
<input checked="" type="checkbox"/> Letter with date, physician name, and diagnosis	_____ Relationship

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Intermountain Hospital from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If patient is a minor, relevant state law should be followed. **Adolescents over the age of 14 must sign authorization, in addition to their parent and/or legal guardian.** Intermountain Hospital will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

- Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days, or according to the relevant state law, from the date this authorization is signed.
- Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
- Refusal to sign:** I understand that I may refuse to sign this authorization and that Intermountain will not condition treatment on whether I sign this authorization.
- Certification:** I certify that I am (check whichever applies):
 - The patient, and the identification that I have provided is true and correct.
 - The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.
- Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
- Copy:** I understand that I will receive a copy of this completed form.

_____	_____	_____	_____
(Date)	(Patient Signature)	(Parent Guardian)	(Date)

_____	_____	_____
(Date)	Staff Member/Witness Signature	(Print Last Name)

 (INTERNAL USE ONLY)

I have received _____ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

_____	_____	_____
(Date)	(Employee Signature)	(Printed Name)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

PATIENT: _____

OTHER LAST NAMES (if any) _____

SOCIAL SECURITY NO.: _____ **DATE OF BIRTH:** _____

This document authorizes **St. Luke's Regional Medical Center**, (hereafter "you"), to release information regarding my medical condition to: **Ada County Mental Health Court, 200 W. Front Street, RM. 505A, Boise, Idaho 83702-7300** (hereafter "Mental Health Court").

The person or organization that receives this authorization has my consent to release/disclose protected health information in accordance with the other terms of this authorization. You may release medical records regarding my medical condition in accordance with the other terms of this authorization, if you are: a medical doctor, physician, surgeon, chiropractor, psychiatrist, psychologist, pharmacist, therapist, medical technician, hemophilia treatment center, nurse, consultant, osteopath, podiatrist, vocational rehabilitation specialist, dentist, orthodontist, hospital, health care clinic, alcohol and/or drug and/or substance abuse treatment center, pharmacy, laboratory or other health care specialist.

I authorize and direct you to copy, release, and deliver to the Mental Health Court **any and all information regarding my health condition in your possession, custody, or control**, including but not necessarily limited to all records, charts, reports, notes, correspondence, bills for treatment or service, and all other documents in your possession relating to any examination, testing, evaluation, diagnosis, treatment, hospitalization, surgery, therapy, counseling, prognosis, or other health care service and/or supplies provided to me, at any time, with regard to any past, present or future mental, emotional, physical or medical disease, illness, impairment, disability, injury or other condition. Please ensure that your response under this authorization and release contains, without limitation, the following types of information:

All information, records, reports, notes, and documents including without limitation:			
<input checked="" type="checkbox"/>	Physical Therapy Records	<input checked="" type="checkbox"/>	Laboratory Reports
<input checked="" type="checkbox"/>	Vocational Rehabilitation Records	<input checked="" type="checkbox"/>	Operative Report
<input checked="" type="checkbox"/>	Prescription Records	<input checked="" type="checkbox"/>	Other: <u>All records of other health care providers in your possession relating to the Patient</u>
<input checked="" type="checkbox"/>	Medication Charts	<input checked="" type="checkbox"/>	Outpatient Department Records
<input checked="" type="checkbox"/>	Discharge Summary	<input checked="" type="checkbox"/>	Pathology Reports and Slides
<input checked="" type="checkbox"/>	Emergency Room Record	<input checked="" type="checkbox"/>	Physicians' Orders and Progress Notes
<input checked="" type="checkbox"/>	Diagnostic Studies	<input checked="" type="checkbox"/>	Slides
<input checked="" type="checkbox"/>	History and Physical	<input checked="" type="checkbox"/>	X-ray, CT scan, MRI, and Other Imaging Reports, and copies of the imaging studies and films
<input checked="" type="checkbox"/>	Nursing assessments, notes, and print-outs of Emtex entries or other electronic entries	<input checked="" type="checkbox"/>	Monitor Strips (EFM, EKG, etc.)

You are authorized and directed to release such information regarding my medical condition, whether the information was initially prepared by you, or by some other person or entity, and even if the person or entity that prepared the information is not associated with or employed by you.

You may accept a photocopy of this authorization, including a faxed copy, as if it were the original.

I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that information has already been released in response to this authorization. Unless otherwise revoked by me in a signed writing, this authorization is valid for a period of two (2) years.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information.

Yes No _____ Initials

Signature of Patient or Personal Representative

Date

Printed Name of Personal Representative (if applicable)

Relationship to Patient

This authorization conforms with the regulations promulgated under § 164.508(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 333 of the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and Section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

PATIENT: _____

OTHER LAST NAMES (if any) _____

SOCIAL SECURITY NO.: _____ **DATE OF BIRTH:** _____

This document authorizes **Saint Alphonsus Regional Medical Center**, (hereafter “you”), to release information regarding my medical condition to: **Ada County Mental Health Court, 200 W. Front Street, RM. 505A, Boise, Idaho 83702-7300** (hereafter “Mental Health Court”).

The person or organization that receives this authorization has my consent to release/disclose protected health information in accordance with the other terms of this authorization. You may release medical records regarding my medical condition in accordance with the other terms of this authorization, if you are: a medical doctor, physician, surgeon, chiropractor, psychiatrist, psychologist, pharmacist, therapist, medical technician, hemophilia treatment center, nurse, consultant, osteopath, podiatrist, vocational rehabilitation specialist, dentist, orthodontist, hospital, health care clinic, alcohol and/or drug and/or substance abuse treatment center, pharmacy, laboratory or other health care specialist.

I authorize and direct you to copy, release, and deliver to the Mental Health Court **any and all information regarding my health condition in your possession, custody, or control**, including but not necessarily limited to all records, charts, reports, notes, correspondence, bills for treatment or service, and all other documents in your possession relating to any examination, testing, evaluation, diagnosis, treatment, hospitalization, surgery, therapy, counseling, prognosis, or other health care service and/or supplies provided to me, at any time, with regard to any past, present or future mental, emotional, physical or medical disease, illness, impairment, disability, injury or other condition. Please ensure that your response under this authorization and release contains, without limitation, the following types of information:

All information, records, reports, notes, and documents including without limitation:			
<input checked="" type="checkbox"/>	Physical Therapy Records	<input checked="" type="checkbox"/>	Laboratory Reports
<input checked="" type="checkbox"/>	Vocational Rehabilitation Records	<input checked="" type="checkbox"/>	Operative Report
<input checked="" type="checkbox"/>	Prescription Records	<input checked="" type="checkbox"/>	Other: <u>All records of other health care providers in your possession relating to the Patient</u>
<input checked="" type="checkbox"/>	Medication Charts	<input checked="" type="checkbox"/>	Outpatient Department Records
<input checked="" type="checkbox"/>	Discharge Summary	<input checked="" type="checkbox"/>	Pathology Reports and Slides
<input checked="" type="checkbox"/>	Emergency Room Record	<input checked="" type="checkbox"/>	Physicians' Orders and Progress Notes
<input checked="" type="checkbox"/>	Diagnostic Studies	<input checked="" type="checkbox"/>	Slides
<input checked="" type="checkbox"/>	History and Physical	<input checked="" type="checkbox"/>	X-ray, CT scan, MRI, and Other Imaging Reports, and copies of the imaging studies and films
<input checked="" type="checkbox"/>	Nursing assessments, notes, and print-outs of Emtex entries or other electronic entries	<input checked="" type="checkbox"/>	Monitor Strips (EFM, EKG, etc.)

You are authorized and directed to release such information regarding my medical condition, whether the information was initially prepared by you, or by some other person or entity, and even if the person or entity that prepared the information is not associated with or employed by you.

You may accept a photocopy of this authorization, including a faxed copy, as if it were the original.

I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that information has already been released in response to this authorization. Unless otherwise revoked by me in a signed writing, this authorization is valid for a period of two (2) years.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information.

Yes No _____ Initials

Signature of Patient or Personal Representative

Date

Printed Name of Personal Representative (if applicable)

Relationship to Patient

This authorization conforms with the regulations promulgated under § 164.508(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 333 of the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and Section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended.

**Idaho Treatment and Recovery Support Services
MENTAL HEALTH COURT**

Direct any and all questions or concerns to: Kelly Jennings Norris, 208-287-7507

Consent for Release of Information

I, _____ am requesting substance abuse services from Idaho's publicly funded substance abuse system of care. As such I voluntarily authorize Business Psychology Associates (BPA), those Substance Abuse Treatment and Recovery Support Services (RSS) providers who are contracted to provide Treatment and RSS under Idaho's publicly funded substance abuse system of care, and the Department of Health and Welfare (Department) to disclose my name, all necessary treatment information and my social security number to each other and the Department. This information will be disclosed for the following purposes: **1)** To assist with referring me to appropriate types of care and guiding my treatment and recovery support; **2)** To be entered into the Department's common client database so that I will have one client number for any services received from the Department; **3)** To process payment of costs for my treatment and recovery support services; **4)** For monitoring compliance in the program; **5)** For program audit and research including independent peer reviewers, contract monitors or researchers appointment by the Department; and **6)** So my client number can be used in preparing statistical reports on the number of persons receiving Drug Court treatment/services through the Department.

Furthermore, I authorize the disclosure of personal substance abuse treatment and recovery outcomes data collected by contracted Substance Abuse Treatment and RSS Providers, BPA and the Department to the Federal Center for Substance Abuse Treatment and its contracted data collection agents. _____ Client Initials

Informed and Voluntary Consent for Treatment

The purpose of my participation, as a client, in the Idaho publicly funded substance abuse treatment program is to acquire knowledge, skills and attitudes supportive of a sober and more satisfying lifestyle.

In addition to the potential positive outcomes likely to occur as a result of my participation, the following reasonably foreseen risks may occur, as they would in any other alcohol and drug treatment program: breach of confidentiality; negative reactions of group members; emotional stress from requirements of group interaction, self-disclosure; stress to relationships resulting from open discussion of issues, past traumas; and, stress to relationships resulting from participant behavioral changes, positive or negative, need to attend recovery support meetings, spend time in group and doing assignments.

Providers will take steps to minimize or protect participants against potential risks by adhering to standards of confidentiality found both in Federal and State Code, and by informing and verifying client understanding of group rules. And, by intervening in and guiding appropriate disclosure, confrontation and resolution in group and in family conflict. Providers will assist clients in accessing sober support services and self help groups where acceptance and stress reducing support is available. _____ Client Initials

Revocation Clause

This release may be revoked at any time either orally or in writing, except to the extent that action has already been taken in reliance on the release. I acknowledge that some information may include material that is protected by State and Federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Information Portability and Accountability Act (HIPAA). Unless revoked as stated above, this consent expires automatically on: _____ Client Initials

I have read the above Consent to Release of Information, Informed and Voluntary Consent for treatment and the Revocation Clause. I agree I have been given the opportunity to question the above disclosures and consent for care and hereby do agree to the above identified Disclosures and Consent to Treatment.

Client Printed Name

Client Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

Witness Printed Name

Witness Signature

Date