



Treatment Court
Authorization for the Use/Disclosure of Information
And Referral Form
Treatment Court Location
Rock County

Today's Date: Participant's Name:
Date of Birth: Address:
Phone/Cell number: Email:
File Number: County: Requested by: Heather Kirchner

I, _____, authorize the Rock County Treatment Court Team and
representatives of the following agencies:

- 1) My alcohol or drug treatment provider(s)
2) Mental Health agencies or provider(s)
3) County Human Services case manager(s)/social worker(s)
4) Department of Corrections/Community Corrections probation agent(s)
5) Service providers for alcohol and drug testing
6) County Sheriff's Department and local Police Department representatives
7) Minnesota Treatment Court Evaluator
8) Treatment Court Judge
9) County Attorney's Office
10) Defense Counsel
11) Treatment Court Coordinator
12) Other
13) Other
14) Other
15) Other

To communicate with and disclose to one another the following information:

- My name and other personal identifying information;
My status as a patient in alcohol/drug treatment and mental health services, including attendance;
My status as a client of County Human Services;
My status as a participant in the Treatment Court Program;
Information pertinent to child removal, custody and reunification issues;
My Treatment Court plan and summaries of my progress in reaching treatment plan goals;
Initial and subsequent evaluations of my service needs by my medical care provider;
Summaries of alcohol/drug and mental health assessment results and history;

State of Minnesota Fifth Judicial District

Blue Earth, Brown, Cottonwood, Faribault, Jackson, Lincoln, Lyon, Martin, Murray, Nicollet, Nobles, Pipestone, Redwood, Rock and Watonwan Counties

- Discharge plan(s) for alcohol/drug treatment and mental health services;
- Date of discharge from alcohol/drug treatment and mental health services, and discharge status;
- Contact with any law enforcement agency during my participation with the court;
- Information and data collected during and after my participation with the Treatment Court Program to be used for research and evaluation purposes;
- Other _____

Purpose:

The purpose of the disclosure authorized in this consent is to: enable the Treatment Court Coordinator and Team Members to evaluate my need for services from the Treatment Court Coordinator and Team Members and coordinate the Treatment Court Coordinator and Team Members services to me.

Acknowledgement:

I know and understand that private health information disclosed pursuant to this authorization may be re-disclosed to other parties only with a further release of information. My alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and can be disclosed only with a further release of information unless otherwise provide for in the regulation. Records concerning mental health services are protected by state law. I am under no obligation to sign this authorization. However, without the requested information the Treatment Court Coordinator and Team Members may not be able to be of assistance and my participation in the Treatment Court Program may be terminated. I may revoke this authorization at any time by giving written notice of revocation. Unless earlier revoked, this authorization expires twelve (12) months from the date of my graduation or termination from the Treatment Court Program.

Participant Signature

Date

Witness Signature

Date

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Step 1- Application (This section is completed by the Prosecuting Attorney, Defense Attorney or Probation)		
County: Choose Location		
Defendant's Name		Birth Date: Click here to enter a date.
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Caucasian; <input type="checkbox"/> Latino/a; <input type="checkbox"/> African-American; <input type="checkbox"/> Asian; <input type="checkbox"/> Native American; <input type="checkbox"/> Other _____		
Street Address:		City: State:
Phone:	In Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	Offense Date: Click here to enter a date.
Defense Attorney Name:		Phone number:
Court file number:		Charges:
Case Status: <input type="checkbox"/> Pretrial <input type="checkbox"/> Post plea <input type="checkbox"/> Plea Date: Click here to enter a date. <input type="checkbox"/> Probation Violation: attach pre-sentence investigation & assessment		
Referred by:		Date Submitted: Click here to enter a date.
Send Application to County Attorney and Treatment Court Coordinator		
PLEASE ATTACH: COMPLAINT, BAIL STUDY, PRIOR RECORD AND/OR CRIMINAL HISTORY, PRE-SENTENCE INVESTIGATION (if applicable), AND CONSENT FOR RELEASE OF INFORMATION		
Step 2- Preliminary Review (completed by Probation and Prosecution)		
PROBATION OFFICE		PROSECUTOR'S OFFICE
Review date: Click here to enter a date.		Review date: Click here to enter a date.
Reviewed by:		Reviewed by:
Defendant a Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Disqualifier Present: <input type="checkbox"/> Yes <input type="checkbox"/> No
Willing to participate: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe LS/CMI Score: Date of LS/CMI Click here to enter a date.		Preliminary Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, go to Step 4.
Preliminary Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No		Comments:
Comments:		
Step 3- Chemical Dependency Assessment		
Assessment Referral Date: Click here to enter a date.		RANT Score:
Chemically Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Recommendations: <input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other _____		
Funding: <input type="checkbox"/> Rule 25 <input type="checkbox"/> Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Unknown		Assessment Completion Date: Click here to enter a date.
Step 4- Team Screening (Completed by Team or Prosecutor)		
Date of Determination: Click here to enter a date.		APPROVED: <input type="checkbox"/> Yes <input type="checkbox"/> No
If denied, state reason (check all that apply)		
<input type="checkbox"/>	Violent History	<input type="checkbox"/> Less than one year probation time remaining
<input type="checkbox"/>	Disqualifying Charge:	<input type="checkbox"/> Undocumented Alien
<input type="checkbox"/>	Unwilling to Participate	<input type="checkbox"/> No Chemical Dependency Issues
<input type="checkbox"/>	Previously Entered Treatment Court Program	<input type="checkbox"/> Unable to Comply (lack of transportation)
<input type="checkbox"/>	Personal Issues:	<input type="checkbox"/> Other:
Comments:		

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Created: July 20, 2017