COURT OF COMMON PLEAS
OF
LAWRENCE COUNTY, PA

Adult Treatment Court
Application & Colloquies

Revised: January 2022

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NOTICE TO ATTORNEYS SUBMITTING APPLICATIONS

Please ensure to have your client (the applicant) complete the following documents in their entirety for review for acceptance into the Lawrence County Treatment Court Program:

- **Treatment Court Application**
- **Releases for Lawrence County Drug & Alcohol (3)**
- **Release for Clover Psychological Association**
- **Release for Human Services Center**
- **Release for the US Department of Veterans Affairs**

(must be included regardless of status as a Veteran)

All required forms must be submitted to the Treatment Court Coordinator. Failure to complete the necessary forms may delay the review and/or acceptance of the applicant into the program. After all documents are received, the Treatment Court Team will review for eligibility. If eligible, the applicant will be assessed by Lawrence County Adult Probation & Lawrence County Drug & Alcohol, and they will be screened for Mental Health disorders. If all eligibility criteria are met, the applicant will be scheduled to be sworn into the Lawrence County Treatment Court. At said hearing, the appropriate colloquy/colloquies, Participant Contract, and Consent for Release of Confidential Information will need to be completed.

If you have any questions about the application or admission process, or the Program itself, please contact the Treatment Court Coordinator at (724) 614-1147.

LAWRENCE COUNTY TREATMENT COURT – APPLICATION

Application must be completed in its entirety, along with all attached releases. Incomplete applications will be returned to the attorney of record and may delay the review/admissions process. For questions, contact the Treatment Court Coordinator by calling (724) 614-1113.

LEGAL REPRESENTATION	
Attorney Name:	Phone:
Address:	Email:
☐ Public Defender ☐ Private/Court Appointed	☐ Application completed by Attorney (if applicable)

CRIMINAL/CHARGE INFORMATION -- TO BE COMPLETED BY DEFENSE ATTORNEY			
PLEASE LIST ALL OTNS FOR WHICH YOUR CLIENT IS APPLYING FOR TREATMENT COURT:			
Do any of the cases include use or possession of a weapon? ☐ Yes ☐ No			

APPLICANT INFORMATION			
Name: *First* *Middle* *Last*			Alias/Maiden:
Physical Address: *Street*	*City*	*State*	*Zip Code*
Mailing Address: *Street* *Same as Above* ☐	*City*	*State*	*Zip Code*
County of Residence:	Currently Incarcerated: ☐ Yes ☐ No		
	Currently on Prob/Parole: ☐ Yes ☐ No		
	If yes, where? Officer?		
Home Phone: ( )	Cell: ( )		Other: ( )
Email:	Primary language spoken:		
Date of Birth:	Social Security Number:		
Race: ☐ Asian/Pacific Islander ☐ Bi-Racial ☐ Black ☐ White ☐ Native ☐ Unknown/Unreported			
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Unknown/Unreported	Gender: ☐ Male ☐ Female		
Height:	Hair Color:	Do you have reliable transportation? ☐ Yes ☐ No	
Weight:	Eye Color:	Primary source of Transportation:	
Do you have a license or ID? ☐ Yes ☐ No	If yes, status: ☐ Valid ☐ Suspended ☐ Expired	License/ID #:	
		State Issued:	
If revoked/suspended, are you able to regain your driver's license? ☐ Yes ☐ No			
Prior participation in a Treatment Court? ☐ No ☐ Yes, specify county:			

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs or alcohol? ☐ Yes ☐ No		Currently abusing? ☐ Yes ☐ No	
If no to either of the above, move on to the next section. If yes to either of the above, please complete the following:			
Drug(s) of Choice:	*1st*	*2nd*	*3rd*
Frequency of use:			
Date of last use:			
Amount used:			
Have you ever received any level of treatment for substance abuse disorder? ☐ Yes ☐ No Are you currently in any level of treatment? ☐ Yes ☐ No			
If yes to the above, explain (inpatient/outpatient, date, location, current/successful/unsuccessful):			
Age first used drugs:	Age first used alcohol:	History of IV Use? ☐ Yes ☐ No	
Are you **currently** prescribed pharmacological interventions (MATs) for substance abuse? ☐ Yes ☐ No	If yes, list medication(s): *(e.g. Methadone, Vivitrol, Suboxone)*		
	Where do you receive this medication from?:		

MENTAL HEALTH HISTORY

Prior psychiatric mental health inpatient/outpatient treatment? ☐ Yes ☐ No	Currently in M/H treatment? ☐ Yes ☐ No
If yes to the questions above, was the mental health diagnosis connected to military service? ☐ Yes ☐ No	
What is the name of your current MH/MR case manager (if applicable):	
Have you been diagnosed by a medical professional with a mental health disorder? ☐ No ☐ Yes, when?	
If yes, who diagnosed you?	Disorder(s) diagnosed?
Are you prescribed any mental health medications? ☐ No ☐ Yes	If yes, list medications:

PHYSICAL HEALTH HISTORY

Medical Insurance:	☐ County Insurance	☐ Private Insurance; specify:
	☐ Medicaid/Medicare	☐ Other/none
If female, are you pregnant? ☐ No ☐ Yes – Due Date:		
List any past or present medical conditions:		
List any medications you are taking:		

EDUCATION, EMPLOYMENT, AND HOUSING STATUS

High level of Education **completed** (select one):

☐ Any grade up to 11th ☐ GED ☐ High School Diploma ☐ Some Trade School

☐ Trade School Graduate ☐ Some College ☐ College Graduate (2 yr) ☐ College Graduate (4 yr)

☐ Some Post-Graduate ☐ Advanced Degree

☐ Current Student School: ☐ Full-Time ☐ Part-Time

Employment Status (select one):

☐ Unemployed ☐ Employed Full-Time (35+ hours/week) ☐ Volunteer

☐ Retired ☐ Employed Part-Time (<35 hours/week) ☐ Disabled

Employer: Address:

Start Date: Occupation:

Primary Source of Support (select all that apply):

☐ Adoption Subsidy ☐ SSI ☐ SSD ☐ Welfare ☐ None

☐ Foster Care Subsidy ☐ Retirement Plan ☐ Workers Comp ☐ Family ☐ Other

☐ Unemployment ☐ Veterans Benefits ☐ Salary/Wages ☐ Disability

Housing Status: ☐ Independent ☐ Dependent *(incarcerated, with friends, etc.)* ☐ Homeless

FAMILY/CHILDREN INFORMATION

Marital Status: ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced ☐ Living Together

Name of Paramour/Partner/Spouse:

# of Children:	# of Dependent Children:	Custody of all minor children: ☐ Yes ☐ No ☐ N/A

Visitation rights for children not residing with you? ☐ Yes ☐ No ☐ N/A

Currently have contact with your primary family? ☐ Yes ☐ No ☐ N/A

Child support amount (if applicable): $ per month

MILITARY HISTORY

Have you (defendant) ever been in the military? ☐ Yes ☐ No *If yes, please answer the questions below.*

Branch:	Enlistment Date:	Years of Service:

☐ Still serving ☐ Dishonorable ☐ Clemency ☐ Other than honorable ☐ General (includes medical)

☐ Honorable ☐ Bad Conduct ☐ Dismissal ☐ Entry level separation

Discharge Date:	Rank at Discharge:
Deployed abroad: ☐ Yes ☐ No	If yes, specify where:
Military combat: ☐ Yes ☐ No	If yes, specify the number of combat zones:

Conflict Era of Service: (Select all that apply) ☐ Korea ☐ Vietnam ☐ ODS (Iraq/Kuwait 1990-2003) ☐ OEF (Afghanistan 2001-present) ☐ OIF (Iraq 2003-2010) ☐ OND (Iraq 2010-present)

Diagnosed with: ☐ PTSD ☐ TBI ☐ MST Eligible for VA benefits: ☐ Yes ☐ No ☐ Unsure

APPLICANT NAME: _____

Signify your acknowledgement and acceptance to the following statements by initialing in the spaces provided.

_____ 1. I understand and acknowledge my acceptance that by submitting this Application, I am waiving my Preliminary Hearing in regard to the above listed case(s).

_____ 2. I understand, and acknowledge, that if my Application is accepted, I will be required to enter a plea of guilty to the above offenses, or stipulate to the parole/probation violation before the Treatment Court Judge.

_____ 3. I understand, and accept, that by Applying to the Treatment Court, I waiving all of my speedy trial rights pursuant to Rule 600 of the Pennsylvania Rules of Criminal Procedure as well as my right to be sentenced, subsequent to my plea of guilty, within ninety (90) days, pursuant to Rule 704 of the Pennsylvania Rules of Criminal Procedure.

_____ 4. I understand and agree to execute all Consents to Release Confidential Information to the Drug Treatment Team regarding any present or past Substance Abuse Treatment Programs, Medical Treatment, Prescribed Medication, and/or any other information the Treatment Court Team may require to design a proper treatment program for me and to monitor the same.

_____ 5. I understand and acknowledge that upon filing this Application with the Clerk of Courts, I will not need to attend any further hearings on the cases involved with this application pending a notification of acceptance or rejection into the Treatment Court Program.

_____ 6. However, I also understand and acknowledge if this application is for Reconsideration for admission into the Treatment Court Program, until I receive notice of acceptance or rejection into the Treatment Court Program, I will continue to appear at all proceedings in my case(s).

_____ 7. I understand and acknowledge that upon acceptance into the Treatment Court Program, this case will be continued generally pending the successful completion or termination of my Treatment Court Treatment Program.

_____ 8. I understand and acknowledge should my application be rejected, my case(s) shall continue through the normal criminal procedure process. However, since I have waived my preliminary hearing in order to file this Application, upon its rejection I will have the option of remanding this case for a preliminary hearing or may choose to file a habeas corpus petition.

_____ 9. I understand that upon Acceptance I will comply with all the requirements of the Lawrence County Court of Common Pleas Treatment Court Program.

The facts set forth in the application are true and correct to the best of my knowledge, information, and belief. I understand that false statements made herein are subject to the penalties of 18 Pa.C.S.A. § 4904 relating to Unsworn Falsification to Authorities.

_____ _____

Signature of Applicant Date

DO NOT COMPLETE THIS SECTION – OFFICIAL COORDINATOR USE ONLY		
Date(s) Distributed for Review		
Received:	*DA:*	*SCA/VJO:*

LAWRENCE COUNTY DRUG AND ALCOHOL COMMISSION, INC.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client DOB _____

I, _____, do hereby consent to and authorize the Lawrence County Drug and Alcohol Commission, Inc. to release to:

LAWRENCE COUNTY TREATMENT COURT TEAM (Team consists of the Lawrence County Courts, Lawrence County Adult Probation and Parole, Lawrence County District Attorney, Lawrence County Public Defender and the Lawrence County Drug and Alcohol Commission, Inc., Jameson Hospital, and Clover Psychological, Lawrence County Government Center, 430 Court Street, New Castle, PA 16101

THE INFORMATION TO BE DISCLOSED IS:

_X_Whether the client is in treatment or is not in treatment

_X__ Demographics

_X__Client's prognosis (how treatment will benefit the client, etc.)

_X__Assessment Recommendation

_X__Nature of the project (purpose, philosophy, program structure, services offered)

_X__Whether the client is or is not in case management

_X__Discussion of progress (client's progress in coming to terms with their addiction)

___ Health Related Emergency Information

_X__Relapse and frequency of relapse

___Other/specify: _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

_X__To provide ongoing treatment/continuing care/supportive services/follow-up.

___To refer for education services.

___To coordinate treatment efforts with my family/concerned person.

_X__To enable judges, attorney, probation/parole officer to support treatment goals or make legal decisions on my behalf.

___To obtain insurance, employment or government benefits.

___To provide health related emergency information.

___Other/specify: _____.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Chapter I, Part 2, and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time verbally or in writing except to the extent that action has been taken in reliance on it. The duration of this authorization is for this admission, and will expire on _____.

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for purpose(s) specified above.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

___ I have been offered a copy of this document and I have: _____ Accepted _____Refused

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Chapter 1, 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. Chapter 1, Part 2. A general authorization for the 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.

LAWRENCE COUNTY DRUG AND ALCOHOL COMMISSION, INC.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client DOB _____

I, _____, do hereby consent to and authorize the Lawrence County Drug and Alcohol Commission, Inc. to release to:

Lawrence County Jail (Name of Person, Facility or Organization)

111 Milton Street New Castle PA 16101 724 654 5384 (Address, City/State or Telephone #)

THE INFORMATION TO BE DISCLOSED IS:

x__Whether the client is in treatment or is not in treatment

x___Client's prognosis (how treatment will benefit the client, etc.)

x___Nature of the project (purpose, philosophy, program structure, services offered)

x___Discussion of progress (client's progress in coming to terms with their addiction)

x___Relapse and frequency of relapse

x___ Demographics

x ___Assessment Recommendation

x___Whether the client is or is not in case management

x___ Health Related Emergency Information

x___Other/specify: eligibility for services

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

___To provide ongoing treatment/continuing care/supportive services/follow-up.

___To refer for education services.

___To coordinate treatment efforts with my family/concerned person.

x___To enable judges, attorney, probation/parole officer to support treatment goals or make legal decisions on my behalf.

___To obtain insurance, employment or government benefits.

___To provide health related emergency information.

___Other/specify: _____.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Chapter I, Part 2, and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time verbally or in writing except to the extent that action has been taken in reliance on it. The duration of this authorization is for this admission, and will expire on _____.

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for purpose(s) specified above.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

___ I have been offered a copy of this document and I have: _____ Accepted _____Refused

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Chapter 1, 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. Chapter 1, Part 2. A general authorization for the 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.

LAWRENCE COUNTY DRUG AND ALCOHOL COMMISSION, INC.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

DOB/INITIALS #: _____

I, _____, do hereby consent to and authorize the Lawrence County Drug and Alcohol Commission, Inc. to release to:

ADMINISTRATIVE OFFICE OF PENNSYLVANIA COURTS (AOPC), Pennsylvania's Problem-Solving Adult and Juvenile Courts Information System (PAJCIS), PA Judicial Center, P.O. Box 61260, Harrisburg, PA 17106

THE INFORMATION TO BE DISCLOSED IS:

_X_Whether the client is in treatment or is not in treatment

_X__ Demographics

_X__Client's prognosis (how treatment will benefit the client, etc.)

_X__Assessment Recommendation

_X__Nature of the project (purpose, philosophy, program structure, services offered)

_X__Whether the client is or is not in case management

_X__Discussion of progress (client's progress in coming to terms with their addiction)

___ Health Related Emergency Information

_X__Relapse and frequency of relapse

___Other/specify: _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

___To provide ongoing treatment/continuing care/supportive services/follow-up.

___To refer for education services.

___To coordinate treatment efforts with my family/concerned person.

_X__To enable judges, attorney, probation/parole officer to support treatment goals or make legal decisions on my behalf.

___To obtain insurance, employment or government benefits.

___To provide health related emergency information.

_X__Other/specify: Data collection and management.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Chapter I, Part 2, and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time verbally or in writing except to the extent that action has been taken in reliance on it. The duration of this authorization is for this admission, and will expire on _____.

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for purpose(s) specified above.

I have been offered a copy of this document and I have: _____ Accepted _____Refused

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Chapter 1, 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. Chapter 1, Part 2. A general authorization for the 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.

CLOVER PSYCHOLOGICAL ASSOCIATION
2722 Wilmington Road, Suite 101
New Castle, PA 16105
724-658-9398 -:- 724-656-1429 (Fax)

AUTHORIZATION FOR RELEASE OF INFORMATION

PERMISSION IS GRANTED TO RELEASE / OBTAIN INFORMATION TO / FROM:

Name of Agency Lawrence County Treatment Court Program
Address 430 Court Street
City, State and Zip Code New Castle, PA 16101
Telephone Number (724) 614-1104
Fax Number (724) 656-1989

REGARDING:

Name of Client	
Address	
City, State and Zip Code	
Telephone Number	
S.S.#	D.O.B:

Dates of Service _____ **to** _____

PURPOSE OF RELEASE:

- ☐ Psychological Evaluation
- ☐ Court Ordered Evaluation
- ☐ Psychotherapy
- ☐ Treatment Planning
- ☐ Consultation re: Current Treatment
- ☒ Other: Treatment Court
- ☐
- ☐ Sexual Offender Assessment
- ☐ Polygraph
- ☐ Abel Assessment
- ☐ Court Ordered Treatment
- ☐ Court Appearance Testimony
- ☐
- ☐

INFORMATION TO BE DISCLOSED:

- ☒ Social / Family History
- ☒ Psychiatric Evaluations
- ☒ Medical Records
- ☒ Forensic Evaluation
- ☒ Military Records
- ☒ Psychological / Evaluation Testing
- ☒ Discharge Summaries
- ☒ Substance History
- ☒ Criminal History
- ☒ Custody Evaluation
- ☒ Vocational Records
- ☒ HIV / AIDS / Infectious Disease
- ☒ Testimony in Court
- ☒ Academic Records
- ☒ Teacher / Counselor Records
- ☐ Other:
- ☒ Permission for Fax Exchange
- ☐ Permission for Verbal Exchange

I have read this authorization and understand its contents and purpose. I understand that I am not obligated to sign my permission for the Release of Information pertaining to me and my dependant(s). I understand that I may cancel this authorization at any time by notifying, in writing, the party responsible for maintaining records ( ) yes or ( ) no. Initials_____

The authorization will automatically expire on _____/_____/_____, or upon completion of a specific condition or event (Specify):
Completion/removal from the Treatment Court Program.

Client's Signature / Guardian Signature _____ Date _____

Client's / Guardian Printed Name _____

Witness Signature _____ Date _____

Printed Name _____

NOTE: It our policy to release only the information generated by the Mental Health Professional.

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.

Revised as of 5-14-07

HUMAN SERVICES CENTER ♦ 130 WEST NORTH STREET ♦ NEW CASTLE PA 16101
MEDICAL RECORDS PHONE: 724-658-3578, EXT. 165/166/167 ♦ FAX: 724-656-1325

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

NOTICE: THIS AUTHORIZATION IS FOR FULL RELEASE OF ALL RECORDS, SUBJECT TO ANY RESTRICTION NOTED BELOW, INCLUDING CLINICAL FINDINGS, DIAGNOSES, TREATMENT, ASSESSMENT, RECOMMENDATIONS FOR FURTHER CARE, DATES OF HOSPITALIZATION AND AMBULATORY VISITS, AND ANY INFORMATION THAT MAY BE RELATED TO DRUG, ALCOHOL, AND/OR PSYCHIATRIC CONDITIONS. NONCONSENSUAL INFORMATION MAY BE RELEASED WITHOUT AUTHORIZATION UNDER APPROPRIATE CIRCUMSTANCES (SEE PA CODE 5100.32.)

Permission is granted to RELEASE / OBTAIN information TO / FROM:

NAME: *LAWRENCE COUNTY TREATMENT COURT TEAM*

ADDRESS: *LAWRENCE COUNTY GOVERNMENT CENTER*
430 COURT STREET

CITY, STATE, ZIP *NEW CASTLE PA 16101*

REGARDING:

_____ **BSU#:** _____
(CONSUMER NAME)

_____ **PURPOSE OF DISCLOSURE:** Continuity of Care
(CONSUMER ADDRESS)

_____
(CONSUMER CITY, STATE, ZIP)

SS#: _____

DATE OF BIRTH: _____

INFORMATION TO BE RELEASED

☒ Social/Family History	☒ Psychological/Educational Testing	☒ Academic Records	☒ Medical History
☒ Psychiatric Evaluation	☒ Discharge Summaries	☐ Teacher/Counselor Observations	☒ Permission for Verbal Exchange
		☒ Permission to FAX Records	☐ Other _____

___ **Yes** ___ **No** I have read this authorization and understand its contents and purpose. I understand that I am not obligated to sign my permission for the Release of Information pertaining to me and my dependent(s). I understand that I may cancel this authorization at any time by notifying, in writing, the party responsible for maintaining records. I have received a copy of the Notice of Privacy Act which explains my right to restrict or revoke the use of my Private Health Information. This authorization will be in effect for one year beginning _____ - _____ - _____ and ending ____-____-_____.

_____ _____
(Consumer Signature) *(Date)*

_____ _____
(Witness Signature) *(Date)*

If the consumer is physically handicapped and/or unable to sign, verbal consent is granted, **two (2) witness signatures** are necessary.

_____ _____
(Witness to Verbal Consent) *(Date)*

_____ _____
(Witness to Verbal Consent) *(Date)*

This information is requested by: _____

NOTE: It is the policy of this agency to release only the information generated by the **HUMAN SERVICES CENTER.**

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.

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

Butler VA Health Care System
353 North Duffy Road
Butler PA 16001

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Lawrence County Treatment Court Team
430 Court Street, New Castle PA 16101
724-614-1104

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☒ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☒ DATE RANGE: all drug screens as deemed relevant by court/probation

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: current list of active medications

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: Verbal/copies of Diagnosis, treatment recommendations/progress, PAJCIS

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): upon completion and/or discharge of the treatment court program and probation

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

VJO will provide summary of progress via written, verbal, telephone, fax, PAJCIS, and secure email that is required by court for monitoring of patient progress in treatment and compliance with legal conditions of Veterans Treatment Court participation, inclusive of all relevant medical record information both past and future.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

LAWRENCE COUNTY COURT OF COMMON PLEAS
TREATMENT COURT PROGRAM

PARTICIPANT CONTRACT

I, _____, with a date of birth of _____/_____/_____ and an address of _____ having entered a guilty plea in criminal case number(s) _____ and/or have stipulating to parole/probation violation in criminal case number(s) _____ hereby enter into this Treatment Court Contract, binding myself to the terms below. _____ (initials)

1. I understand that the validity of this contract is conditioned upon my eligibility for the Treatment Court Program. If at any time after the execution of this agreement and in any phase of the Treatment Court program, it is discovered that I am, in fact, ineligible to participate in the program, I may be immediately terminated from the program and sentenced at the discretion of the presiding Judge. In the case of a guilty plea, I will not be allowed to withdraw my previously entered plea of guilty unless my ineligibility is based on facts or information which should have been known to the prosecutor prior to admission into the program, or upon Constitutional grounds. _____ (initials)

2. I understand that if I enter this program and fail to complete it, I may be barred from future participation. _____ (initials)

3. I understand that participation in Treatment Court involves a minimum time commitment of 18-24 months but may extend longer depending on my individual progress in the program. _____ (initials)

4. I will report as directed to my Treatment Court Officer and attend all appointments for treatment and ancillary services as scheduled. _____ (initials)

5. I understand that during the course of the Treatment Court Program, I will be required to attend court sessions as directed and that failing to attend will result in a warrant for my arrest. _____ (initials)

6. For the purposes of regularly scheduled status hearings, I agree to waive my right to have my attorney of record present. I understand that my case may be discussed without my attorney or the prosecutor present. _____ (initials)

7. I agree to cooperate in an assessment/evaluation for planning an individualized course of treatment for drug & alcohol and/or mental health, in order to adequately meet my needs. I agree to execute the Consent for Disclosure of Confidential Substance Abuse information. _____ (initials)

8. I understand that my individual course of treatment may include but is not limited to: residential or outpatient treatment, education, and/or self-improvement courses, that may be imposed at the discretion of the Treatment Court team. I agree to adhere to all recommended treatment programs and sign appropriate releases, allowing treatment providers to release information as it relates to my individualized treatment plan. _____ (initials)

9. I will not leave any treatment program without prior approval of the Treatment Court Team and my treatment provider. I agree to complete all required financial disclosure declarations as necessary to obtain funds for my treatment. If funding is not available, I understand that I am responsible for the costs of my treatment. _____ (initials)

10. I agree to keep the Treatment Court Team informed of my current address and phone number at all times and will not change my residence without prior consent from my Treatment Court Officer. My place of residence is subject to Treatment Court approval. _____ (initials)

11. I will not travel more than thirty (30) miles from my address of record without receiving prior permission from my Treatment Court Officer or the Treatment Court Coordinator. I will not travel outside of Pennsylvania without written permission from the Officer or Coordinator. _____ (initials)

12. I understand that I must comply with all local, state, and federal laws. I agree to inform any law enforcement officer who contacts me that I am in Treatment Court. I must immediately notify the Treatment Court Officer of any contacts, arrests, or investigations by/with a law enforcement agency. _____ (initials)

13. I understand that I may not, under any circumstances, work as a confidential informant with any law enforcement agency while I am participating in the Treatment Court Program. I may not be made or encouraged to work as a confidential informant as a condition of my participation in the Treatment Court Program. _____ (initials)

14. I will not possess, have control of, or have in my place of resident or vehicle any of the following: stolen property, non-prescribed controlled substances, drug paraphernalia, firearms, or deadly weapons/instruments of crime. I will submit my person, property, place of residence, vehicle, and/or personal effects to search at any time by a member of the Treatment Court Team or representative based upon reasonable suspicion that I am in possession of the aforementioned items. _____ (initials)

15. I understand that I may not participate in Treatment Court if I am a gang member. _____ (initials)

16. I understand that any false statements, verbal or written, made by me to any member of the Treatment Court Team may result in termination from the program. _____ (initials)

17. I agree not to threaten, harass, intimidate, or abuse in any way any member of the Treatment Court Team or its representative. _____ (initials)

18. I understand that I am not permitted to be romantically involved with other Treatment Court participants or any member of the Treatment Court team. _____ (initials)

19. I understand that participating in the Treatment Court program, I am required to be drug and alcohol free at all times. I will not associate with people who possess drugs, nor will I be present while drugs are being used or possessed by others. _____ (initials)

20. I agree to submit to urinalysis and/or breathalyzer testing on a random basis, as directed and according to procedures established by the Treatment Court Team and/or treatment provider. I understand that refusal to submit to testing, failing to report for testing, and/or failure to provide a sample for testing will be considered a positive test and a violation of this Contract. _____ (initials)

21. I will not substitute, alter, or in any way attempt to change my bodily fluids or testing specimen, including attempting to dilute the sample or provide a sample other than my own. _____ (initials)

22. I understand that I may dispute positive test results and request a laboratory confirmation. I am responsible for the reimbursement of the costs associated with laboratory fees in the event of a positive confirmation of drug use. _____ (initials)

23. I am responsible for what goes in my body. Before taking medication of my kind, prescribed or over the counter, I will check to ensure that it is non-narcotic, non-addictive, and contains no alcohol. I will inform any treating physicians that I may not take narcotics or addictive medications. If a treating physician wishes to treat me with narcotic or addictive medications, I must disclose this to my treatment provider and probation officer and get specific permission from the Treatment Court Team to take such medication. I will sign appropriate release forms, as necessary. _____ (initials)

24. I understand that during the initial phases of the Treatment Court program, I may be precluded from working or gaining employment. I further understand that within the time directed by the Treatment Court Team, I will seek legitimate employment, job training, and/or education as approved by the Team. _____ (initials)

25. I understand that I must pay all fines, costs, restitution, and fees associated with my participation in the Treatment Court Program. At the time designated by the Treatment Court Officer, I will enter into a monthly payment agreement and adhere to the agreement made. _____ (initials)

26. I agree to inform the Lawrence County Domestic Relations Office and/or Lawrence County Children & Youth Services of my participation in Treatment Court, as long as I have open cases with such agencies. I agree to sign appropriate releases for all parties involved with said agencies to allow for communication on my status and progress in the Treatment Court Program. _____ (initials)

27. I agree to abide by the rules and regulations imposed by the Treatment Court Team and understand that failure to comply may result in service adjustments, sanctions, and/or termination from the program. _____ (initials)

28. I understand that upon entering the Treatment Court Program, I am waiving my right to be sentenced within ninety (90) days from entering a plea of guilty and/or stipulation to a parole/probation violation. This waiver is required to meet the time commitments of the Treatment Court Program. _____ (initials)

29. I understand that I may voluntarily withdraw from Treatment Court at any time. If I do so, I may be sentenced up to the maximum penalty allowed for the underlying offense(s) and at the discretion of the presiding Judge. _____ (initials)

30. I understand that my failure to successfully compete and graduate from the Lawrence County Court of Common Pleas Treatment Court Program will result in the imposition of the previously deferred sentencing and/or sentencing for a violation of parole/probation. I understand that my failure to complete the program cannot be a basis for the withdrawal of my previously entered guilty plea and/or stipulation to my parole/probation violation(s). I understand that any attempt to withdraw my guilty plea and/or stipulation to parole/probation violation(s) would be prejudicial to the Commonwealth. Any sentence imposed shall be at the discretion of the presiding Judge. _____ (initials)

31. If the charges for which I entered into Treatment Court are new criminal charges, upon successful completion of the Treatment Court Program and the payment of all outstanding costs, fines, fees, and restitution, the criminal charges filed against me will be dismissed. The District Attorney's Office will agree to seek to expunge the pertinent charges, subject to court approval. _____ (initials)

32. If the charges for which I entered into Treatment Court were the result of a parole/probation violation, upon successful completion of the Treatment Court Program, any remaining term of supervision may be terminated. I understand that parole/probation violation cases are not eligible to be expunged. _____ (initials)

33. I acknowledge that failure to pay costs, fines, fees, and restitution will result in all open cases being referred to a collections enforcement agency and may reflect negatively upon my dismissal and/or expungement of charges. _____ (initials)

34. I understand that failure to adhere to the aforementioned conditions may result in my termination from the Treatment Court Program. _____ (initials)

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, or have had read to me, the foregoing rules, regulations, and conditions of participation in the Treatment Court Program. I understand that the Treatment Court Program is constantly improving, therefore, it may be necessary for me to review, and sign updated contracts during the course of the program. I am willing to enter into this agreement to participate in the Lawrence County Court of Common Pleas Treatment Court Program.

Participant's Signature	Date
Attorney for the Participant	Date
Attorney for the Commonwealth	Date

COURT OF COMMON PLEAS
LAWRENCE COUNTY, PENNSYLVANIA
TREATMENT COURT

Commonwealth of Pennsylvania	:	**CRIMINAL DIVISION**
	:	
vs.	:	**NO: _____**
	:	
_____	:	

TREATMENT COURT GUILTY PLEA COLLOQUY

INSTRUCTIONS

1. This form is to be used ONLY in the Lawrence County Court of Common Pleas Treatment Court.
2. The Court will explain to you your rights, the elements of the crime(s) to which you are pleading guilty and the possible ranges of sentences and/or fines.
3. Complete the answer to every question.
4. Be sure to sign and date the last page of this form.

YOU ARE PRESENT BEFORE THIS COURT BECAUSE YOU AND YOUR LAWYER HAVE STATED THAT YOU WISH TO PLEAD GUILTY TO ALL OF THE CRIMINAL OFFENSES WITH WHICH YOU HAVE BEEN CHARGED.

1. Can you read, write, speak and understand the English language? _____
2. Within the last twenty-four (24) hours have you ingested any alcohol or drug, prescription or otherwise? _____ If yes, are you in any way under the influence of alcohol or drugs, including prescription medications? _____

3. Do you understand that you are here today to enter a plea of guilty to all of the criminal charges against you? _____

4. Do you understand that pleading guilty is a condition of participation in the Lawrence County Treatment Court? _____

5. Do you understand that if you are terminated from the Treatment Court Program, you will NOT be permitted to withdraw you guilty plea, unless that termination is based on facts which should have been known to the prosecutor PRIOR to admission, or is based upon Constitutional grounds? _____

6. Do you understand that if it becomes necessary to sentence you pursuant to your guilty plea, then the sentencing may NOT occur within the ninety (90) days as proscribed by Pa. Rule of Criminal Procedure 704? _____ Further, by initialing, you signify that you understand and agree to waive the ninety (90) days sentencing limitation due to your participation in the Treatment Court Program. _____ (initials)

7. Do you understand that this is an open plea stipulation and should it become necessary to sentence you, it is the Treatment Court Judge who will determine the sentence (in other words, this is an open plea)? _____

8. Do you understand that upon sentencing (should that be necessary) the Treatment Court Judge in fashioning your sentence, in addition to considering the statutory maximum sentences proscribed by law for the offense you are pleading guilty, as indicated below, will consider your prior criminal history, including juvenile adjudications and the sentencing guidelines. The statutory maximum sentence(s) you may face for the offense(s) you are now pleading guilty are as follows:

CASE #	OTN #	CHARGE	GRADE	CRIMES CODE	MIN/MAX TERM OF CONFINEMENT	MAX FINE

9. Do you understand that if you are being sentenced on more than one offense, and/or more than one count of an offense, the sentences could be consecutive to each other? _____

10. Do you understand that you have a right to a trial by jury and that by pleading guilty you are giving up that right? _____

11. Do you understand that a jury would consist of twelve (12) citizens from Lawrence County, and that you and your attorney would participate in the selection of the jury and that in order to convict you, all twelve members of the jury must agree that you are guilty, beyond a reasonable doubt? _____

12. Do you understand that you are presumed innocent until proven guilty by the Commonwealth beyond a reasonable doubt? _____

13. Do you understand that the Commonwealth must prove each element of each offense beyond a reasonable doubt? _____

14. Do you understand that if the judge declines to accept your guilty plea, you will be permitted to withdraw it and you will be in the same position as if this plea had not taken place? _____

15. Do you understand the terms and conditions of the Treatment Court Program? _____

16. Is it your decision to plead guilty? _____

17. Have you been threatened or forced, in any way, to plead guilty? _____

18. Have any promises been made to you to enter a plea of guilty, other than the terms of the Treatment Court Program as agreed to by you in the Participant Contract? _____

19. Do you understand that a guilty plea has the same effect as a conviction by a jury or a judge hearing the case without a jury? _____

20. Have you discussed your guilty plea and your entry into the Treatment Court Program with your attorney? _____

21. Are you satisfied that you understand the responsibilities and consequences of your plea of guilty? _____

22. And, are you entering this guilty plea, freely and voluntarily? _____

I, _____, having been fully informed of my rights, voluntarily and knowingly agree to waive these rights and enter a PLEA OF GUILTY to the offenses listed above at paragraph 8, by signing this TREATMENT COURT GUILTY PLEA COLLOQUY.

_____ _____

Defendant Date

I have reviewed this Treatment Court Guilty Plea Colloquy with my client, and acknowledge that he/she has been fully informed of the Adult Court Program and the consequences of entering a guilty plea. I further certify that he/she is signing freely and voluntarily.

_____ _____

Attorney for Defendant Date

COURT OF COMMON PLEAS
LAWRENCE COUNTY, PENNSYLVANIA
TREATMENT COURT

Commonwealth of Pennsylvania	:	**CRIMINAL DIVISION**
	:	
vs.	:	**NO: _____**
	:	
_____	:	

TREATMENT COURT PROBATION/PAROLE VIOLATION STIPULATION COLLOQUY

INSTRUCTIONS

1. This form is to be used ONLY in the Lawrence County Court of Common Pleas Treatment Court.
2. The Court will explain to you your rights, the elements of the violation to which you are stipulating.
3. Complete the answer to every question.
4. Be sure to sign and date the last page of this form.

YOU ARE PRESENT BEFORE THIS COURT BECAUSE YOU AND YOUR LAWYER HAVE STATED THAT YOU WISH TO ADMIT/STIPULATE TO PAROLE/PROBATION VIOLATION(S) WITH WHICH YOU HAVE BEEN CHARGED.

1. Can you read, write, speak and understand the English language? _____
2. Within the last twenty-four (24) hours have you ingested any alcohol or drug, prescription or otherwise? _____If yes, are you in any way under the influence of alcohol or drugs, including prescription medications? _____
3. Do you understand that you are here today to stipulate/admit the violations filed against you? _____
4. Do you understand that the admission/stipulation is a condition of participation in the Lawrence County Treatment Court? _____
5. Do you understand that if you are terminated from the Treatment Court Program, you will NOT be permitted to withdraw your stipulation/admission, unless that termination is based on facts which should have been known to the prosecutor PRIOR to admission, or is based upon Constitutional grounds? _____
6. Do you understand that if it becomes necessary to sentence you pursuant to your stipulation/ admission, then the sentencing may NOT occur within the ninety (90) days as proscribed by Pa. Rule of Criminal Procedure 704?

_____Further, by initialing, you signify that you understand and agree to waive the ninety (90) days sentencing limitation due to your participation in the Treatment Court Program. _____ (initials)

7. Do you understand that this is an open plea stipulation and should it become necessary to sentence you, it is the Treatment Court Judge who will determine the sentence (in other words, this is an open plea)? _____

8. Do you understand that upon sentencing (should that be necessary) the Treatment Court Judge in fashioning your sentence, in addition to considering the statutory maximum sentences proscribed by law for the underlying offense(s) upon which you are admitting/stipulating violation of your probation and/or parole as indicated below, will consider your prior criminal history, including juvenile adjudications and the sentencing guidelines. The statutory maximum sentence(s) you may face for the underlying offense(s) you are now admitting to or stipulating to the violations of your parole/probation are as follows:

CASE NUMBER	DATE OF VIOLATION(S)	VIOLATIONS ALLEGED

UNDERLYING CHARGE(S) and GRADING	MAXIMUM TERM OF CONFINEMENT	MAXIMUM FINE

9. Do you understand that if you are being sentenced on more than one underlying offense, and/or more than one count of an offense, the sentences could be consecutive to each other? _____

10. Do you understand that you are presumed innocent until proven guilty by the Commonwealth beyond a reasonable doubt? _____

11. Do you understand that if the judge declines to accept your admission/stipulation, you will be permitted to withdraw it and you will be in the same position as it had not taken place? _____

12. Do you understand the terms and conditions of the Treatment Court Program? _____

13. Is it your decision to plead admit/stipulation to the violation(s)? _____

14. Have you been threatened or forced, in any way, to admit/stipulate? _____

15. Have any promises been made to you to enter an admission/stipulation, other than the terms of the Treatment Court Program as agreed to by you in the Participant Contract? _____

16. Do you understand that an admission/stipulation has the same effect as a conviction by a judge hearing the case? _____

17. Have you discussed your admission/stipulation and your entry into the Treatment Court Program with your attorney? _____

18. Are you satisfied that you understand the responsibilities and consequences of your admission/stipulation? _____

19. And, are you entering this admission/stipulation, freely and voluntarily? _____

20. Do you have any questions that have not been addressed by your attorney or this Court that you with to have addressed at this time? _____

    If so, please indicate: _____

I, _____, having been fully informed of my rights, voluntarily and knowingly agree to waive these rights and ADMIT/STIPULATE to the violations listed and the maximum sentences you could face for these violations as listed above at paragraph 8, by signing this TREATMENT COURT GUILTY PLEA COLLOQUY.

_____ _____

Defendant Date

I have reviewed this Treatment Court Violation Admission/Stipulation Colloquy with my client, and acknowledge that he/she has been fully informed of the Adult Court Program and the consequences of entering an admission/stipulation. I further certify that he/she is signing freely and voluntarily.

_____ _____

Attorney for Defendant Date

IN THE COURT OF COMMON PLEAS
LAWRENCE COUNTY, PENNSYLVANIA

Commonwealth of Pennsylvania	:	**CRIMINAL DIVISION**
	:	
vs.	:	**NO: _____**
	:	
_____	:	

ORDER OF LIMITED RELEASE OF
SPECIFIC SUBSTANCE ABUSE TREATMENT RECORDS

AND NOW, this_____ day of _____, 20_____, this matter is before the Court for consideration of the limited release of specific substance abuse treatment records. The Court makes the following findings:

1. On the _____ day of _____, 20_____, the defendant was accepted into the Lawrence County Court of Common Pleas Treatment Court Treatment Program.
2. As a condition of participation in the Treatment Court Treatment Program, the defendant must attend substance abuse treatment and the Treatment Court Team must monitor the defendant's progress in substance abuse treatment.
3. The defendant has voluntarily and knowingly signed a HIPAA and 42 C.F.R. Part 2 compliant release.
4. The information necessary to monitor the defendant's progress in substance abuse treatment includes:
    a. Defendant's diagnosis, defendant's urinalysis results, defendant's treatment attendance or nonattendance, defendant's cooperation with treatment, defendant's progress in treatment, and defendant's prognosis. This treatment information is the minimum necessary to carry out the purposes of the disclosure. *See, 45 C.F.R. §165.502(b)(11) and C.F.R. §2.13(a).*

IT IS THEREFORE ORDERED THAT:

1. **_____(Treatment Provider) shall provide to the members of the Lawrence County Treatment Court Team** (as reflected HIPAA/42 C.F.R. Part 2 Consent to Release Form or team member replacement) **the following information.**

    a. **Defendant's diagnosis, defendant's urinalysis results, defendant's treatment attendance or nonattendance, defendant's cooperation with treatment, defendant's progress in treatment, and defendant's prognosis.**

    b. **The named treatment provider shall continue to provide the treatment information until defendant's successful completion of or termination from the Lawrence County Treatment Court Treatment Program or further Court Order, whichever shall first occur.**

    c. **The Treatment Court Team shall not re-disclose the information received pursuant to this Order, except as may be provided by law.**

BY THE COURT:

_____

Dominick Motto,
President Judge

IN THE COURT OF COMMON PLEAS
LAWRENCE COUNTY, PENNSYLVANIA

Commonwealth of Pennsylvania	:	**CRIMINAL DIVISION**
	:	
vs.	:	**NO: _____**
	:	
_____	:	

VOLUNTARY PROGRAM WITHDRAWAL COLLOQUY

I hereby voluntarily and knowingly withdraw my participation in Treatment Court. _____

I have not been threatened or coerced in making this decision; I have had ample opportunity to consider this decision and consult with counsel if I so desired. _____

I understand that by withdrawing from Treatment Court I will avoid the imposition of a sanction. I understand that I have the right to challenge a violation resulting in a jail sanction and that by withdrawing; I am not exercising that right. _____

I understand that by withdrawing from Treatment Court, I will be sentenced on the charge(s) or underlying charge(s) of the probation/parole violation to which I had previously pled guilty or stipulated. Any sentence shall be at the sole discretion of the Treatment Court Judge. _____

I understand that withdrawing from Treatment Court will be subject to sentencing for the charge(s) to which I have pled guilty and/or considered a violation of my probation/parole sentence and a violation hearing will be held. _____

I further understand and agree that in withdrawing from Treatment Court, I forever waive my right to challenge the violation of my Treatment Court agreement in any Court. _____

I understand that upon withdrawing from Treatment Court, I may not re-apply on my current charge or any future charges and may only be readmitted to the Program by special order of Court.

Participant Signature: _____ Date: _____

Attorney Signature: _____ Date: _____