COURT OF COMMON PLEAS
OF
LAWRENCE COUNTY, PA

Adult Treatment Court
Application & Releases

Revised: January 2022

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

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, Human Services Center, Butler Veteran's Affairs and the Lawrence County Drug and Alcohol Commission, Inc.). 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___ 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)

x___ Health Related Emergency Information

x___Relapse and frequency of relapse

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: