

**MARION COUNTY MENTAL HEALTH COURT
APPLICATION**

PLEASE PRINT

Date: _____

MHC Case # _____

Last Name: _____ First Name: _____ MI: _____

Sex (M/F): _____ Date of Birth: _____ Race: _____

Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address if different: _____

Telephone: Home: _____ Work: _____ Cell: _____

Driver's license or state ID card: (Circle one) Yes / No DL or ID Card Number: _____

Social Security Number: _____

How long have you lived in Marion County: _____

Emergency Contact: Name: _____

Telephone#(s): _____ Relationship: _____

Address: _____

Current Charge(s): _____

Case#: _____

Currently in jail (Please Circle one): Yes / No If so, date of incarceration: _____

Previous Convictions: _____

Attorney's Name: _____

Public Defender/Firm Name: _____

Phone Number: _____

The Marion County Mental Health Court does not discriminate against qualified applicants and on the basis of race, color, religion, gender, age, national origin, marital status, handicap (disability) or veteran status or as otherwise prohibited by federal, state or local law.

MARION COUNTY MENTAL HEALTH COURT APPLICATION

The purpose of, and need for, this exchange of information is to provide information about my eligibility for, and participation in, Mental Health Court's application process. The information to be exchanged may include information about my diagnosis which will include, but is not limited to: medical history, including current assessments, diagnosis, treatment and medications, arrest and prior criminal record, risk and alcohol/drug use assessment and diagnosis information.

The Mental Health Court Treatment team members are; the presiding Mental Health Court Judge, Assistant State Attorney, Public Defender, or other Defense Counsel, Mental Health Court Coordinator, Court Alternatives Supervisor/staff, NAMI representative and Law Enforcement in their capacity as a Mental Health Court team member.

I agree that the disclosure of the above information, prior to Mental Health Court termination, sentencing, and / or revocation of this consent shall not be a breach of my right to confidentiality.

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

Signature of applicant

Date

Name of attorney (Please Print)

Signature of attorney

Date

Please return the completed referral along with the Consent for Disclosure to:
The Clerk of the Court, County Criminal, Room 101

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MARION COUNTY MENTAL HEALTH COURT

CASE NUMBER: _____

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, hereby give my permission
(Name of Defendant)

for an ongoing exchange of information among _____
(Treatment Provider)

and the following individuals and agencies working together in the Marion County Mental Health Court

- Mental Health Court Presiding Judge
- Office of the State Attorney
- Public Defender / other Defense Counsel
- Mental Health Court Coordinator/staff
- Court Administration, in their capacity as a mental health court team member
- Sheriff's Office, in their capacity as a mental health court team member
- Probation Staff
- NAMI representative, in their capacity as a mental health court team member
- Other service agencies who are providing services and treatment to participants of this court
- My victim(s), to the extent my information is in the pre-sentence investigation report

and also _____
Name of Person, Relationship

The purpose of, and need for, this exchange of information is to provide information about my eligibility for and participation in the Marion County Mental Health Court, about the treatment I need, and about my progress. The information to be exchanged may include information about my diagnosis, treatment plan, treatment attendance, program compliance, progress, and prognosis related to each Mental Health Court phase of participation. This information will allow the Team to plan and coordinate the services I need, to impose appropriate sanctions or incentives for my behavior, to submit billings for my services, to maintain data about me, and to audit, evaluate, or conduct research about Mental Health Court activities and effectiveness. It will also allow any persons named in this consent (such as family members) to be involved in my Mental Health Court activities. I further understand that some or all of this information will be discussed in open court. The nature of the information to be shared will include, but is not limited to: medical history, including current assessments, diagnosis, treatment and medications, arrest and prior criminal record, risk and alcohol/drug use assessment and diagnosis information, treatment plans, court directives, drug test results, progress reports, reports of program compliance and other related behavior, and recommendations for services, sanctions, and incentives.

Office of the Court Administrator, Fifth Judicial Circuit
Marion County Court Alternatives
112 North Magnolia Avenue
Ocala, Florida 34475

Telephone: 352/401-6728 Facsimile: 401-6726

MARION COUNTY MENTAL HEALTH COURT

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

I understand that this consent will remain in effect until there has been a formal and effective termination of my involvement with the Mental Health Court for the above referenced case, EITHER by my successful completion of the Mental Health Court requirements OR upon sentencing for my original offense, if I am terminated from Mental Health Court, OR upon written revocation. I understand that revoking this consent will result in my termination from Mental Health Court. I agree that the disclosure of the above information, prior to Mental Health Court termination, sentencing, and/or revocation of this consent shall not be a breach of my right to confidentiality. I further understand that individuals and agencies working together in the Marion Mental Health Court will file Mental Health Court forms in my underlying misdemeanor court file and that the forms will be open to public inspection."

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

Date

Defendant's Signature

Printed Name

Notice to Receiving Person or Organization: Prohibiting Re-disclosure w/o Consent

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse and mental health treatment made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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