MARION COUNTY MENTAL HEALTH COURT
APPLICATION

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: _____

LAST FOUR ONLY of 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 application along with the Consent for Disclosure to:
Office of the Court Administrator, Fifth Judicial Circuit
Marion County Court Alternatives
110 NW 1st Avenue, Room 1062
Ocala, Florida 34475
E-mail/scan it to agordian@circuit5.org
Questions, please call Adaly Gordian 352-401-6769

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

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.

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.

The Marion County Mental Health Court does not discriminate against qualified applicants 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.

Office of the Court Administrator, Fifth Judicial Circuit
Marion County Court Alternatives
110 NW 1st Avenue, Room 1062
Ocala, Florida 34475
Telephone: 352-401-6769 Facsimile: 401-7896

SMA Healthcare
Authorization to Release Confidential Information

Client Name: _____ MR#: _____

Date of Birth: _____ Social Security Number: _____ Date: _____

I, the undersigned, authorize SMA Healthcare, Inc. (SMA) to disclose or obtain the information specified below from the medical records of the above named client in accordance with Florida Law and Federal Law. I understand that this Authorization extends to all and any part of my medical records, which may include information regarding: records of minors; history, diagnosis, treatment, and/or testing of Drug or Alcohol Use, Mental Health, or Communicable Disease, including STD, HIV, and AIDS/ARC. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by state or federal law.

Access Code (Pin Number): _____

☑ Information may be disclosed to:
☑ Information may be obtained from:

Name: Marion County Mental Health Court Telephone #: _____

Address: 110 NW 1ST Ave City: Ocala

State: FL Zip Code: 34475 Email: _____ Fax #: 352-401-7896

Method of Disclosure: (check all that apply) ☐ Verbal/Telephone ☑ U.S. Mail ☐ Pick-up ☐ Fax ☑ Secured Email **(MR Only)**

Dates of information requested when a paper/electronic copy is provided: _____ to _____

Disclosure of: ☐ Enrichment ☐ Primary Care ☑ Substance Use ☐ Mental Health

Purpose of Disclosure:

☐ Client Request Copies ☑ Department of Children & Families Investigation ☑ Financial ☑ Litigation/Legal
☐ Continuity of Care/Treatment ☑ Discharge Planning ☐ Laboratory ☐ Social Security
☑ Other (specify): _____

Information to be Disclosed: Place your initials (letter of your first and last name) in the space(s) below:

____ Comprehensive Assessment	____ Laboratory Results	____ Progress in Treatment
____ Discharge Summary	____ Letter of Attendance	____ Psychiatric Evaluation
____ Financial/Demographic Information	____ Medical Note **(Primary Care Only)**	____ Screening
____ History and Physical (H&P)	____ Medication Record	____ Treatment Plan

____ Other (specify): _____

I understand that I have the right to revoke this Authorization in writing at any time and that the revocation will not be effective retroactively for disclosures that have already occurred based on this Authorization. I also understand that this Authorization will **expire one (1) year** from the date of signature as it appears below, unless I revoke this Authorization prior to that time. I am signing this Authorization voluntarily; I have the right to refuse to sign. My ability to receive treatment, payment, or my eligibility for benefits will not be affected whether or not I sign this Authorization.

SMA charges a reasonable and customary fee for reproduction of records.

_____ _____
Signature of Client Date
Verbal consent was obtained ☐ Yes* ☐ NA

_____ _____ _____
Signature of Staff/Credentials (witness) ID # Date

_____ _____ _____
Signature of Parent/Legal Guardian, if applicable Relationship Date
(Proof of Guardianship must be submitted with this request.)

_____ _____ _____
Signature of Staff/Credentials (second witness*) ID # Date

Health Information Management: 5664 SW 60th Ave, Ocala, FL 34474 Phone: (352) 291-5555 Fax: (352) 291-5586

Notice to Recipient of Information:
42 CFR part 2 prohibits unauthorized disclosure of these records.