Approved/Denied/Referred to other Treatment Court Case # _____

OTN_____ Probation/Parole Violation: YES/NO

APPLICATION FOR TREATMENT COURT

Please check the appropriate court you are applying for:

Mental Health Court: _____

NAME _____ **AGE** _____

DATE OF BIRTH _____ **S.S.#** _____

ADDRESS _____ **PHONE** _____

CITY _____ **STATE** _____ **ZIP** _____

Length at present address: _____ List below **five** years prior residences:

_____

_____

_____

Place of Employment _____ Medical Insurance: Y or N

Do you have a current driver's license? Y or N If not, why? _____

Driver's License Number/State:_____

Date of Arrest _____ Blood Alcohol Content (BAC) _____

Are you currently on Probation/Parole? _____ State or County: _____ In Jail? _____

List all current charges: _____

Prosecuting Agency/Officer: _____ District Justice: _____

Attorney Name: _____ Phone: _____

Drug User: _____ Drug Choice: _____ Length of Use: _____

Alcohol User: _____ Frequency: _____ Length of Use: _____

Mental Health Issues/Diagnosis: _____

Physician: _____ Medications: _____

Caseworker: _____ Who referred you to this program? _____

Are you currently attending counseling or involved in any programs? _____

List Agency _____

*Date of Formal Arraignment: _____

Have you applied for or participated in any treatment court programs in this or any other county? _____

If yes, what county(ies)? _____

Signature: _____ Date: _____

Referral Source Signature: _____ Date: _____

For Official Use Only. Do not write in the space below.

_____ Application Rec'd	_____ Sent to DA	_____ Sent for Assessment
_____ Police Liaison	_____ Assessment Compl.	_____ To Committee

---

DISTRICT ATTORNEY ELIGIBILITY

RECOMMENDED:

NOT RECOMMENDED:
(WHY?)

COMMENTS:

THE WEST BRANCH DRUG AND ALCOHOL ABUSE COMMISSION
CASE MANAGEMENT UNIT
CONSENT OF RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby consent to and authorize the West Branch Drug and Alcohol Abuse Commission Case Management Unit, to, as indicated below release to:

_____
Name of person/agency

_____
Address/Telephone

the following information pertaining to myself. The information to be disclosed is:

___Whether the client is or is not in treatment
___The nature of the project
___Whether or not the client has relapsed
___The Prognosis/Diagnosis of the client
___A Brief Description of the client's progress
___Other (specify) _____

The information is needed for the following purpose:

___Referral for treatment services
___To monitor the provision of ongoing treatment
___To enable judges, attorneys, probation/parole officers to support treatment goals and/or make legal decisions on the client's behalf
___To obtain insurance, employment or government benefits
___Referral to intensive case management
___Other (specify) _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, 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 other drug abuse patient.

I may revoke this consent to release information at any time except to the extent that action has been taken in reliance of it. When applicable, criminal justice system clients who have agreed to enter treatment in lieu of prosecution or punishment may not revoke their consent that allows the court, probation, parole, or other criminal justice agency from monitoring their progress in treatment.

_____I have been offered a copy of this document and I have ____Accepted
____Refused

_____
Signature of client Date

_____
Signature of witness Date

_____
Specify date, event or condition upon which release will expire.

LYCOMING-CLINTON MENTAL HEALTH/INTELLECTUAL DISABILITY PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION

[ ] 200 East Street
Sharwell Building
Williamsport, PA 17701

[x] 8 North Grove St, Suite A
Lock Haven, PA 17745

I authorize the use/disclosure of information about me as described below:

Name: _____ Birthdate: _____ Social Security #: _____

Address: _____ City: _____ State: PA Zip: _____

Day Phone:

PROVIDER/REQUESTOR: I AUTHORIZE LYCOMING-CLINTON MH/ID PROGRAM TO:

[ ] RELEASE TO: **OR** **[x] RECEIVE FROM:**

Provider/Requestor _____

Name Address

INFORMATION TO BE DISCLOSED: Dates of Treatment from _____ to _____

[ ] Psychological Evaluation	[ ] Psycosocial History	[ ] Psychiatric Evaluation
[ ] Social History	[x] Medical History/Records	[ ] School Records
[ ] Drug and Alcohol History	[ ] Progress Reports	[ ] Discharge Summary
[ ] Financial Benefits/Records	[ ] DPA Benefits	[ ] Social Security Benefits
[ ] Insurance /Pension	[ ] VA Benefits	[ ] Other: _____

SPECIAL AUTHORIZATION: My evaluation, diagnosis, and/or treatment may be released to the requestor noted above as indicated by my initials next to the information to be released.

[ ] Behavioral Health [ ] HIV/AIDS [ ] Alcohol and/or drug abuse or dependence

REASON FOR THE RELEASE:

[ ] Insurance	[ ] Legal	[x] Continued Care
[ ] Personal	[ ] Other Specified:	

REVOCATION:

I understand that I may revoke this authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is not effective to the extent that action has been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

I understand that providing authorization for the requested use or disclosure is not a condition of my treatment, payment enrollment in a health plan or eligibility for benefits except (1) if my treatment is related to research; or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third part.

This authorization shall be in force and effect until_____. (Note: must specify (a) an expiration date; or (b) an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository).

AUTHORIZATION:

I authorize the provider to release the information above to the requestor.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

IF PATIENT IS UNABLE TO CONSENT BECAUSE OF AGE OR PHYSICAL CONDITION, PLEASE COMPLETE ONE OF THE FOLLOWING:

Patient (is a minor____ years of age) OR (is unable to give consent because_____

_____

Patient Representative's Signature_____ Relationship_____Date:_____

This information has been disclosed to you from records whose CONFIDENTIALITY is protected by State Law. Pennsylvania State Regulations prohibit you from making any further disclosure of this information without the prior written consent of person with respect to whom it pertains.