Treatment Court
Authorization for the Use/Disclosure of Information And Referral Form

Treatment Court Location
Pipestone County

Today's Date: ___________________ Participant's Name: _________________________________

Date of Birth: ___________________ Address: ____

Phone/Cell number: ______________ Email: ____

File Number: ___________________ County: ___________ Requested by: Heather Kirchner

I, ______________________________, authorize the Pipestone County Treatment Court Team and representatives of the following agencies:

1) My alcohol or drug treatment provider(s)
2) Mental Health agencies or provider(s)
3) County Human Services case manager(s)/social worker(s)
4) Department of Corrections/Community Corrections probation agent(s)
5) Service providers for alcohol and drug testing
6) County Sheriff's Department and local Police Department representatives
7) Minnesota Treatment Court Evaluator
8) Treatment Court Judge
9) County Attorney's Office
10) Defense Counsel
11) Treatment Court Coordinator
12) Other ___________________________________
13) Other ___________________________________
14) Other ___________________________________
15) Other ___________________________________

To communicate with and disclose to one another the following information:

☐ My name and other personal identifying information;
☐ My status as a patient in alcohol/drug treatment and mental health services, including attendance;
☐ My status as a client of County Human Services;
☐ My status as a participant in the Treatment Court Program;
☐ Information pertinent to child removal, custody and reunification issues;
☐ My Treatment Court plan and summaries of my progress in reaching treatment plan goals;
☐ Initial and subsequent evaluations of my service needs by my medical care provider;
☐ Summaries of alcohol/drug and mental health assessment results and history;

☐ Discharge plan(s) for alcohol/drug treatment and mental health services;
☐ Date of discharge from alcohol/drug treatment and mental health services, and discharge status;
☐ Contact with any law enforcement agency during my participation with the court;
☐ Information and data collected during and after my participation with the Treatment Court Program to be used for research and evaluation purposes;
☐ Other ____

Purpose:
The purpose of the disclosure authorized in this consent is to: enable the Treatment Court Coordinator and Team Members to evaluate my need for services from the Treatment Court Coordinator and Team Members and coordinate the Treatment Court Coordinator and Team Members services to me.

Acknowledgement:
I know and understand that private health information disclosed pursuant to this authorization may be re-disclosed to other parties only with a further release of information. My alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and can be disclosed only with a further release of information unless otherwise provide for in the regulation. Records concerning mental health services are protected by state law. I am under no obligation to sign this authorization. However, without the requested information the Treatment Court Coordinator and Team Members may not be able to be of assistance and my participation in the Treatment Court Program may be terminated. I may revoke this authorization at any time by giving written notice of revocation. Unless earlier revoked, this authorization expires twelve (12) months from the date of my graduation or termination from the Treatment Court Program.

____	______________________
Participant Signature	Date
____	______________________
Witness Signature	Date

Step 1- Application (This section is completed by the Prosecuting Attorney, Defense Attorney or Probation)

County: Choose Location

Defendant's Name	Birth Date: Click here to enter a date.

☐ Male ☐ Female

☐ Caucasian; ☐ Latino/a; ☐ African-American; ☐ Asian; ☐ Native American; ☐ Other ________

Street Address: City: State:

Phone:	In Custody: ☐ Yes ☐ No	Offense Date: Click here to enter a date.

Defense Attorney Name:	Phone number:
Court file number:	Charges:

Case Status: ☐ Pretrial ☐ Post plea ☐ Plea Date: Click here to enter a date.

☐ Probation Violation: attach pre-sentence investigation & assessment

Referred by:	Date Submitted: Click here to enter a date.

Send Application to County Attorney and Treatment Court Coordinator

PLEASE ATTACH: COMPLAINT, BAIL STUDY, PRIOR RECORD AND/OR CRIMINAL HISTORY, PRE-SENTENCE INVESTIGATION (if applicable), AND CONSENT FOR RELEASE OF INFORMATION

Step 2- Preliminary Review (completed by Probation and Prosecution)

PROBATION OFFICE	PROSECUTOR'S OFFICE
Review date: Click here to enter a date.	Review date: Click here to enter a date.
Reviewed by:	Reviewed by:
Defendant a Resident: ☐ Yes ☐ No	Disqualifier Present: ☐ Yes ☐ No
Willing to participate: ☐ Yes ☐ No ☐ Maybe LS/CMI Score: Date of LS/CMI Click here to enter a date.	Preliminary Approved: ☐ Yes ☐ No If No, go to Step 4.
Preliminary Approved: ☐ Yes ☐ No Comments:	Comments:

Step 3- Chemical Dependency Assessment

Assessment Referral Date: Click here to enter a date.	RANT Score:

Chemically Dependent: ☐ Yes ☐ No

Recommendations: ☐ Inpatient ☐ Intensive Outpatient ☐ Halfway House ☐ Other ________________

Funding: ☐ Rule 25 ☐ Insurance ☐ Self-pay ☐ Unknown	Assessment Completion Date: Click here to enter a date.

Step 4- Team Screening (Completed by Team or Prosecutor)

Date of Determination: Click here to enter a date.	**APPROVED: ☐ Yes ☐ No**

If denied, state reason (check all that apply)

☐	Violent History	☐	Less than one year probation time remaining
☐	Disqualifying Charge:	☐	Undocumented Alien
☐	Unwilling to Participate	☐	No Chemical Dependency Issues
☐	Previously Entered Treatment Court Program	☐	Unable to Comply (lack of transportation)
☐	Personal Issues:	☐	Other:

Comments: