

PLATTSBURGH MENTAL HEALTH COURT

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION TWO-WAY/Mandated Legal

DOB	
SS#	

I, _____, hereby authorize the

Plattsburgh Mental Health Court Team

[whose members are the Mental Health and
Chemical Dependency Service Providers listed below,
the City Court Judge, Clinton County District Attorney,
Defense Attorney and Clinton County Probation Department]

- ◆ **Behavioral Health Services North (BHSN)**, 63 Broad St., Plattsburgh, NY 12901
563-8000 fax 563-9001
- ◆ **Clinton County Mental Health Clinic (CCMHC) & Addiction Services (CCAS)**,
16 Ampersand Dr., Plattsburgh, NY 12901 565-4060
fax 566-0168 (**CCMHC issues**) fax 562-2783 (**CCAS issues**)
- ◆ **Champlain Valley Physicians Hospital (CVPH)**, 75 Beekman St., Plattsburgh, NY
12901 562-7048 fax 562-7144
- ◆ **Champlain Valley Family Center (CVFC)**, 20 Ampersand Dr., Plattsburgh, NY 12901
561-8480 fax 566-6382
- ◆ **Clinton County Jail**, 25 McCarthy Drive, Plattsburgh, NY 12901
565-4351 fax 565-4343

and any mental health or substance abuse treatment program that has provided me services to communicate with and disclose to one another the following information: *(initial each category that applies)*

- _____ my name and other individually identifying information;
- _____ my compliance with personal referral for arranging an evaluation/assessment session;
- _____ my attendance at the assessment;
- _____ my pre-admission screening information;
- _____ my status as a patient in alcohol/drug treatment and summaries of my alcohol and/or drug treatment history;
- _____ my status as a patient in mental health treatment and summaries of my psychiatric treatment history;
- _____ my medical history EXCEPT confidential HIV-related information;
- _____ my bio-psychosocial evaluation;

_____ information from my alcohol/drug and/or mental health clinical record, including: my date of admission; diagnosis; medication compliance; summary of my treatment plan, progress, and compliance; discharge plan, date of discharge, and discharge status; urinalysis results; my compliance with recommended treatment, referrals, and continuing care;

_____ all information on my compliance with, and participation in, mental health or chemical dependency services while I am in the Plattsburgh Mental Health Court;

_____ Prescribed Medications;

and _____ (other)

The purpose of and need for the disclosure is to determine my eligibility, and to inform the Plattsburgh Mental Health Court Team of my compliance with and ongoing participation in any required treatment, medication management, and to develop appropriate treatment and continuing care plans.

I consent that information about my Plattsburgh Mental Health Court application and participation may be provided to State University of New York at Plattsburgh Professor Richard Schnell, Assistant Professor David Stone, and/or supervised graduate students in CLG 554: Research Design & Methods, who have been designated to collect data and evaluate the Plattsburgh Mental Health Court, so long as my confidentiality is protected.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164, and that my mental health records are protected under New York State Mental Hygiene Law Section 33.13 and HIPAA. None of these records can be re-disclosed by the Plattsburgh Mental Health Court Team without my written authorization, unless otherwise provided for under federal or state law or regulations.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon the disposition of my Mental Health Court case or three years from the date below, whichever is first.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided with a copy of the form.

Date: _____

Signature of Client

Date: _____

Defendant's Attorney

Form date: 6-13-08