Collaborative Court Participant Packet (Version September 3, 2024)

This Packet Contains the Following Forms:

- SUPCR 1131 Collaborate Courts Referral Information Sheet
- SUPCR 1132 Collaborate Courts Contact and Information
- SUPCR 1133 Collaborative Courts Release of Information (Substance Use)
- SUPCR 1134 Collaborative Courts Release of Information (Mental Health)
- BH 306 Authorization to Release / Share Confidential Information
- Veterans Release of Information
- Veterans SF180 Military Records
- CAFES Release of Information

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SANTA CRUZ
COLLABORATIVE COURTS OFFICE
701 OCEAN STREET
SANTA CRUZ, CA 95060
(831) 420-2498
www.santacruzcourt.org

Collaborative Courts Referral Packet

Mental Health Diversion (MHDA):

Mental Health Diversion is based on AB 1810 (PC 1001.35 & PC 1001.36). This legislation gives discretionary diversion of qualified persons who have committed a crime because of mental health disorder. Diversion may be granted during the pretrial stage at any time after the filing of an accusatory pleading.

Eligibility Criteria:

- Have a recent mental health diagnosis from a "qualified mental health provider".
- Mental health was a significant factor in the charged offense.
- Not pose "an unreasonable risk of danger to public safety" as defined in Section 1170.1, if treated in the community.
- Be able to respond to treatment goals.
- Waive the right to a speedy trial.
- Agree to comply with treatment goals.
- Agree with treatment goals developed by a treating provider.

Exclusionary Factors:

- Offence of murder or voluntary manslaughter.
- Any 290 offence except PC 314.
- Offence of PC 11418, weapon of mass destruction.
- Diagnosis of Antisocial Personality Disorder, Borderline Personality Disorder, or Pedophilia.

Behavioral Health Court Assessment (BHCA)

Behavioral Health Court is a collaborative court that serves individuals who are on formal probation and living with a serious mental health disorder that significantly impairs their daily functioning.

Eligibility Criteria:

- On formal probation with Santa Cruz County Mental Health Terms.
- Struggling with a significant and persistent mental health disorder that contributes to substantial functional impairment(s).
- Eligible for MOST Team Probation supervision or assigned to a specified mental health probation caseload.
- Eligible for Santa Cruz County Medi-Cal.
- Amenable to participation in BHC, attend residential treatment programs as recommended, and take medication as prescribed.

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Veteran Court Assessment (VCA)

Veteran Court (VC) mission is to assist justice system-involved veterans and their families with opportunities to improve the quality of life through a collaborative effort among justice system partners, community-based organizations, and county and national veteran's services. The VC is a peer-support based court program, operating under CA Penal Code § 1170.9 and 1001.80, which provides for alternative sentencing for veterans with service-related mental health issues.

Eligibility Criteria:

- Served in the United States Military, regardless of length of service, combat experience, or characterization of discharge.
- Struggles with a diagnosis of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), military sexual trauma (MST), substance use, or other mental health symptoms directly related to military service (PC § 1170.9 eligible).
- Amenable to participation in the program and voluntarily agree to all conditions including treatment for their qualifying condition.

Exclusionary Factors:

- No PC § 290), arson (PC § 457.1) or gang registrants.
- No PC § 667.5(c) current or prior violent felony conviction(s).
- No case where the victim in the current offense has suffered death or great bodily injury (permanent disfigurement or permanent disability).

Collaborative Courts Referral Process:

- Fill out *Contact Information Form*
- Client completes and signs all *Releases of Information* (ROI)
- Request a Collaborative Court Clinician Assessment (CCCA) from the court for all in-custody clients.
- If client has any additional mental health records including, out of Santa Cruz County records, please include that documentation with this referral packet.
- After the packet is received, collaborative courts will contact referral person or attorney for interview and next steps.
- Upon receiving the packet, collaborative courts will contact the referral person or attorney to arrange an interview and discuss next steps.

- The court Clinician will follow up with the court after determining eligibility and suitability.
- A psychological evaluation or clinician screening may be needed for Mental Health Diversion, Veterans Court, or Behavioral Health Court.

Please allow up to one to three weeks to complete the process.

Return referral packet to the collaborative courts box located in the Judge's Chambers Office or email to collaborativecourts@santacruzcourt.org. If you have questions email collaborativecourts@santacruzcourt.org

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Collaborative Courts Contact and Information Form

Penal Codes: ☐ 1001.8 ☐ 1170.9 ☐ 1001.36 ☐ 1001.35

Client Name:_____ Date of Referral:_____

DOB: _____ Sex: _____ Phone number: _____

Referral Source Name: _____ Referral Source Phone Number: _____

Case Number(s) _____

Offense(s) _____

Charge Level: ☐ Felony ☐ Misdemeanor

☐ Violation of Supervision ☐ Other

In Custody: ☐ Main Jail ☐ Rountree ☐ Blaine St.

☐ R&R ☐ Out of Custody

Military Service: ☐ Yes ☐ No ☐ Unknown

If yes, provide SSN _____

Military Service Types of Discharge:

☐ Honorable ☐ General ☐ Other than honorable

☐ Bad conduct ☐ Dishonorable

Enrolled in VA Services: ☐ Yes ☐ No

Has been declared PC 1368: ☐ Current ☐ Past

☐ No ☐ Unknown

Healthcare insurance: ☐ Yes ☐ No

Insurance Provider: _____

County: _____

Primary Care Provider:

Name: _____

Contact number: _____

Psychiatrist:

Name: _____

Contact number: _____

Therapist:

Name: _____

Contact number: _____

Mental Health Diagnosis:

1) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report

2) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report

3) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report

Psychiatric Medications:

1) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report

2) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report

3) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report

Please list all of support services/case managers/coordinator/providers/programs you are currently connected with: (TAY, MOST, Emeline, HPHP, Housing Matters, CCCIL, Encompass, Front Street, etc.):

_____

_____

_____

_____

_____

_____

QUESTIONNAIRE

1. Are you currently employed?
   ☐Yes ☐No
2. Any hospitalizations in the last 12 months? (Dominican, Telecare, Watsonville Hospital, etc.)
   ☐Yes ☐No
3. Do you have a permanent physical or mental disability that limits or impacts your daily living? (i.e., wheelchair, amputation, unable to climb stairs?)
   ☐Yes ☐No ☐Maybe
4. How often do you feel angry, sad, stressed, or depressed?
   ☐Daily ☐Weekly ☐Monthly ☐Seasonal ☐Yearly ☐Never
5. Do you need any help getting your prescriptions filled and taking your medications?
   ☐Yes ☐No ☐Maybe
6. Do you struggle with time management and organization?
   ☐Yes ☐No ☐Maybe
7. How well do you manage your medical appointments?
   ☐Extremely well ☐Somewhat well ☐Neutral ☐Somewhat not well ☐Extremely not well
8. Drugs and alcohol usage: Do you currently use any substances or alcohol? Are you in remission? Are you interested in treatment?
   ☐No ☐Yes- I am currently using and not interested in treatment ☐I am in remission ☐Yes- I am using and I am interested in treatment ☐I do not want to answer
9. Do you have a hard time completing tasks?
   ☐Yes ☐No ☐Maybe

10. Are you currently able to take care of basic needs such as bathing, changing clothes, using a restroom, getting food and clean water and other things like that?
☐Yes ☐No ☐Maybe

11. Are you familiar with Santa Cruz County available resources? (Cal Fresh, Medi-Cal, NAMI, AA/NA, Food pantry, Dientes, Mental Health services, ACCESS, etc.)
☐Yes ☐No ☐Maybe

By signing below, you acknowledge that you have received information about mental health diversion, you are open to being assessed, and you are interested in receiving mental health services. This includes participating in mental health programming as recommended, taking all medication as prescribed, abstaining from all substances, submit to testing and follow directives of mental health provider.

Participant Signature _____ Date _____

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SANTA CRUZ

SANTA CRUZ BRANCH
701 Ocean Street, Room 120
Santa Cruz, CA 95060

WATSONVILLE BRANCH
1 Second Street, Room 300
Watsonville, CA 95076

Authorization for Use, Exchange, and/or Discharge of Confidential Substance Use Disorder Information for entry and participation in the Collaborative Courts

I _____, _____
(print name of client or client's representative) (print date of birth)

hereby authorize the Superior Court of Santa Cruz Collaborative Courts, to disclose ☐Mental Health information, ☐Health information, ☐Substance Use treatment history, ☐HIV test results and status, ☐ Written Assessments ☐Other (specify): _____

to:

Santa Cruz County Department of Probation:

(Name) _____

☐ Santa Cruz County District Attorney Representative:

(Name) _____

☐ Santa Cruz County Public Defender Representative:

(Name) _____

☐ Department of Veterans Affairs:

(Name) _____

☐ Santa Cruz County Health Services Agency:

(Name) _____

☐ Santa Cruz County Sheriff's Department:

(Name) _____

☐ California Department of Corrections and Rehabilitation:

(Name) _____

☐ Goodwill of Central Coast

(Name) _____

☐ Other: _____

Purpose of disclosure: To help assess and determine appropriate treatment, progress, and compliance with the Collaborative Courts.

Consent: Without my express cancellation or change, this consent remains in effect until my participation in Collaborative Court is terminated or completed. "Termination" is when my participation in Collaborative Court ends before I finish the program. "Completion" is when I successfully complete participation in Collaborative Court. I may cancel or change this authorization at any time by submitting a written request to the Superior Court of Santa Cruz County. A cancellation or change goes into effect once the written request is received by the Superior Court of Santa Cruz County. I have a right to refuse to sign this authorization. The Superior Court of Santa Cruz, Collaborative Courts, may refuse to conduct an assessment if I do not authorize the release of medical and mental health information to the Collaborative Court team. I have a right to a copy of this authorization. A recipient of medical information pursuantto this authorization may not further disclose the medical information except in accordance with a new authorization that meets the requirements of California Health and Safety Code section 56.11, or as specifically required or permitted by law.

Signature: _____ Date: _____

If signed by someone other than the client, state your legal relationship:

_____

Witness: _____ Date: _____

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SANTA CRUZ

SANTA CRUZ BRANCH
701 Ocean Street, Room 120
Santa Cruz, CA 95060

WATSONVILLE BRANCH
1 Second Street, Room 300
Watsonville, CA 95076

Authorization for Use, Exchange, and/or Discharge of Confidential Mental Health and Medical Information for entry and participation in the Collaborative Courts

I _____, _____
(print name of client or client's representative) (print date of birth)

hereby authorize the Superior Court of Santa Cruz Collaborative Courts, to disclose ☐Mental Health information, ☐Health information, ☐Substance Use treatment history, ☐HIV test results and status, ☐ Written Assessments ☐Other (specify): _____ to:

☐ Santa Cruz County Department of Probation:
(Name) _____

☐ Santa Cruz County District Attorney Representative:
(Name) _____

☐ Santa Cruz County Public Defender Representative:
(Name) _____

☐ Department of Veterans Affairs:
(Name) _____

☐ Santa Cruz County Health Services Agency:
(Name) _____

☐ Santa Cruz County Sheriff's Department:
(Name) _____

☐ California Department of Corrections and Rehabilitation:
(Name) _____

☐ Goodwill of Central Coast:
(Name) _____

☐ Other: _____

Purpose of disclosure: To help assess and determine appropriate treatment, progress, and compliance with the Collaborative Courts.

Consent: Without my express cancellation or change, this consent remains in effect until my participation in Collaborative Court is terminated or completed. "Termination" is when my participation in Collaborative Court ends before I finish the program. "Completion" is when I successfully complete participation in Collaborative Court. I may cancel or change this authorization at any time by submitting a written request to the Superior Court of Santa Cruz County. A cancellation or change goes into effect once the written request is received by the Superior Court of Santa Cruz County. I have a right to refuse to sign this authorization. The Superior Court of Santa Cruz, Collaborative Courts, may refuse to conduct an assessment if I do not authorize the release of medical and mental health information to the Collaborative Court team. I have a right to a copy of this authorization. Substance use disorder records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Signature: _____ Date: _____

If signed by someone other than the client, state your legal relationship:

_____

Witness: _____ Date: _____

1

1400 Emeline Avenue,
Santa Cruz, CA 95060
Phone: (831) 454-4170
Fax: (831) 454-4663

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

1430 Freedom Blvd. Ste F,
Watsonville, CA 95076
Phone: (831) 454-4170
Fax: (831) 454-4663

Client Legal Name:			Avatar No:
Nickname/Alias:	Date of Birth:		Phone:
Address:	City:	State:	Zip:

2

AUTHORIZATION for the RELEASE/SHARE of CONFIDENTIAL INFORMATION

I, _____(PRINT NAME of LEGAL AUTHORIZOR) authorize **Behavioral Health Services** _ ☑ **MHP or** ☐ **SUDS** (*check appropriate box*) **Staff** to share (give and/or receive) the below identified information to: (AGENCY/ENTITY) authorized to receive my treatment information. [CARES Act *permits "organization/agency" for SUD disclosures.]*

Recipient Name: _____

Address: _____ Phone: _____

[**FOR Children's Mental Health (CBH) staff (minor ownership)**: *My signature below confirms that I have assessed this 12-17 year old minor and determined the minor* ☐ *does* ☐ *does not have the capacity to authorize the release of her/their/his protected health information.]* _____/_____ (CBH Staff Signature/Date)

3

The purpose for the communication, disclosure and exchange of this information is:

☒ Facilitate treatment/payment/operational coordination ☑ Summarize treatment
☐ Other (Specify reason): _____
☐ Claims Assistance ☐ Quality of Care Review/Complaint ☐ Appointment Support/Scheduling Help

4

I permit staff to release/share the following sensitive information: [please check appropriate boxes]:

☒ All Mental Health Treatment Information: **FROM** _____ **TO** _____ [Optional: *Specify Unique Date Limit*]
☑ All Substance Use Disorder Treatment Information: **FROM** _____ **TO** _____ [**REQUIRED for SUD**: *Specify Unique Date Range Limits – 42 CFR section 2.31*]
☐ Only the following information (can specify any type and/or date range): _____
_____
_____
☑ Diagnosis ☐ Only treatment enrollment confirmation ☑ Psychiatry treatment, including medications
☐ HIV/AIDS Test Results (A separate authorization is required for each disclosure & **required signer initials**): _____

5

DURATION: This authorization is valid until: _____ (Date or event) or one (1) year from the date this form is signed, whichever date is earlier.

6

MY RIGHTS: (1) I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or eligibility for benefits.**(2)** I understand that this is a communication release.**3)** I understand if I authorize disclosure of my protected health information to someone who is not covered by confidentiality laws (such as a family friend) it is possible that my information may be re-disclosed by that person to someone else.**(4)** I may revoke this authorization at any time by submitting a written revocation to: Quality Improvement, 1400 Emeline Avenue, Santa Cruz, CA 95060 to activate the revocation effective date.**(5)** I have the right to a copy of this authorization form and was offered a copy.(*Initial:* ___)

7 Client Signature:	Date:

8

Parent/Legal Guardian Signature: _____ **Date:** _____
(If signed by someone other than the client, state your legal relationship to the client): _____
Behavioral Health Staff (Print/Sign): _____ **Date:** _____
Legal Guardian or Conservator must provide a copy of current legal appointment papers to receive information

Release of Information Form Instructions

1
- Please fill out client information in Box 1
- Behavioral Health Staff can help with the Avatar Number

2
- Client to enter name on the first line
- Client to mark the type of Behavioral Health Services provider who is **authorized to release or share** treatment information: Choose: "MHP" box for mental health treatment provider or "SUDS" box for substance use disorder treatment provider. Both boxes can not be selected.
- Recipient Name: Client to enter person's name or entity/organization and fill in address and phone number of entity who can **receive** treatment information.
    - If Client wants SUD staff to share information with MH staff, Enter "Behavioral Health Services"
- If Client receiving mental health services is a minor 12 years of age or older and wants to release information, then Children's Mental Health (CBH) staff box needs completion before form is valid.

3
- Check any box(s) that describes the reason for the exchange or disclosure of this information

4
- Check any box(s) that describes what type of information you are permitting staff to release or share.
- Note that for Mental Health treatment entering a "From" and "To" Date is **optional**
- Note that for Substance Use Disorder treatment information "From" and "To" date is **required**
- Note that for HIV / AIDS Test Results to be released you must initial the form and a separate authorization is required for each HIV / AIDS disclosure

5
- Indicate how long the authorization is valid
- This release is valid beginning immediately when you sign the form
- You can indicate an end date that is any time up to one (1) calendar year (12 months) from the date you sign the form
- If no end date is entered, the release will expire 12 months from the date the form is signed

6
- Your RIGHTS – Please read!
- You have a right to have a copy of this authorization. Please initial that you have been offered a copy

7
- Sign and date the release of information

8
- If you are not the client, describe your relationship to the client and legal authority to sign the form
- You may be required to provide legal paperwork
- Behavioral Health staff may sign the form as a staff witness

Client Name: _____ Client #_____ SUDS

Santa Cruz Office
1400 Emeline Avenue
Santa Cruz, CA 95060
Phone: (831) 454-4170
Fax: (831) 454-4663

Watsonville Office
1430 Freedom Blvd. Suite F
Watsonville, CA 95076
Phone: (831) 763-8200
Fax: (831) 763-8231

SUBSTANCE USE SERVICES CONSENT FOR ELECTRONIC HEALTH RECORD EXCHANGE

County of Santa Cruz Behavioral Health Services, and Network Providers utilize a secure, shared Electronic Health Record (EHR) system called Avatar to store your Protected Health Information (PHI). PHI that is stored in the shared EHR system includes but is not limited to your personal identifying information, payment information, assessments, treatment plans, progress notes, medications, and drug testing results. Having your PHI stored in the shared EHR system provides many benefits to you by allowing your care providers faster access to your health records and enabling them to better coordinate your care to ensure the best possible treatment for you. In the event of an emergency or disaster, consenting to allow your treatment providers to access your PHI in the shared EHR allows your care providers to give you faster, more effective, timely treatment when it matters most. County of Santa Cruz Behavioral Health Services and Network Providers are committed to upholding the confidentiality of all EHR stored in Avatar in accordance with both federal and State privacy regulations including Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 and the CARES Act. Only providers directly involved with your care have authorization to access your EHR for the purposes of treatment, payment, or healthcare operations.

Current List of Avatar Providers

County of Santa Cruz Mental Health Treating Providers ● County of Santa Cruz SUD Treating Providers Encompass Mental Health Treating Providers ● Encompass Community Recovery SUD Treating Providers ● Janus of Santa Cruz SUD Treating Providers ● Sobriety Works SUD Treating Providers● New Life Community Center SUD Treating providers ● Volunteer Center Mental Health Treating Providers ● Front Street Mental Health Treating Providers ● Pajaro Valley Prevention & Student Assistance Mental Health Treating Providers ● Pajaro Valley Prevention & Student Assistance SUD Prevention Treating Providers ● Haven of Hope Mental Health Treating Providers ● Parent Center Mental Health Treating Providers ● Telecare Crisis Stabilization Program ● Horizon Service Providers

How Is My Privacy Protected?

County of Santa Cruz Behavioral Health Services and participating Network Providers use a combination of safeguards to protect your PHI. Technical safeguards include encryption, password protection and the ability to track every viewer's usage of the system. All participating providers must agree to follow written policies controlling access to information through the shared EHR system. Participating providers must follow federal 42 CFR Part 2, CARES Act and HIPAA regulations; in addition to federal and State privacy laws. Please reference our Notice of Privacy Practices that was provided to you for more information.

Your Consent Rights

You have the right to either give or deny consent to have your PHI exchanged with participating network providers in the shared EHR system. If you deny consent, to exchange your PHI over the shared EHR system, it will not affect your ability to obtain treatment or your eligibility for benefits. When you deny consent, your EHR will be "sequestered", meaning your PHI will be stored in the EHR system but will only be viewable to the agency where you currently receive services. With the exception of your first and last name, your EHR would not be searchable to anyone else in the network. When "sequestered" your treatment providers from different programs will not be able to view or share information with each other over the shared EHR system. Having your EHR sequestered will impact your providers ability to get access to the most relevant treatment information about you, which would impact their ability to coordinate your services in a timely manner and provide you with the best quality of care.

If you give consent for your PHI to be exchanged over the shared EHR, you have the right to revoke your consent at any time. This revocation must be in writing. You also have a right to request, in writing, a list of entities to whom your information has been disclosed within the last two years. The County must respond within 30 days to this written request. You have a right to receive a copy of this consent form. If you have any questions or concerns about how your information will be stored, used, or accessed through the shared EHR system you may contact the *Quality Improvement at 1-800-952-2335.* Submit all written requests to: *Quality Improvement, 1400 Emeline Ave. 2nd Floor, Santa Cruz, CA 95060*

Your Consent Choices (initial only one):

_____ **I GIVE CONSENT** for all authorized providers who are part of my treatment team within County of Santa Cruz Behavioral Health Services and included Network Providers to exchange my (PHI) through the shared EHR system for the purposes of treatment, payment or healthcare operations in accordance with HIPAA, 42 CFR Part 2 and the CARES Act regulations.

_____ **I DENY CONSENT** for the County of Santa Cruz Behavioral Health Services and included Network Providers to exchange my (PHI) through the shared EHR system for any reason unless the law specifically permits it without my consent. I understand that my information will still be stored on the shared EHR system but will be sequestered and not accessible to any of the other network providers except for my first and last name.

DURATION: This consent is valid until the end of treatment unless it is revoked in writing.

_____	_____	_____	_____
Client Signature	Date	Client Printed Name	Date

_____	_____
Parent/Legal Guardian Signature or Authorized Representative	Date

_____	_____
Printed Name (Parent/Legal Guardian or Authorized Representative)	Date

County of Santa Cruz

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 EMELINE AVENUE, SANTA CRUZ, CA 95061-0962

SANTA CRUZ HEALTH CENTER
1080 EMELINE AVE.
SANTA CRUZ, CA 95060
(831) 454-4100 FAX (831) 454-4296

WATSONVILLE HEALTH CENTER
1430 FREEDOM BLVD.
WATSONVILLE, CA 95076
(831) 763-8400 FAX (831) 763-8237

TDD: (831) 454-4123

OUTPATIENT MEDICAL CLINICS DIVISION

AUTHORIZATION TO RELEASE INFORMATION FROM MEDICAL RECORDS

I, _____

Hereby authorize

_____
_____
_____

(name and address of person or organization)

To furnish to

_____
_____
_____

(name and address of person or organization)

any and all records obtained in the course of my diagnosis and treatment, which pertain to and may include the mention of alcohol and/or drug abuse, psychiatric illness, HIV+, AIDS Related Complex (ARC), and/or Acquired Immune Deficiency Syndrome (AIDS), concerning:

_____ _____
(patient's name) (patient's social security number)

_____ _____
(patient's date of birth) (patient's medical record number)

The disclosure of records is required for the following purposes: _____

_____

The disclosure shall be limited to the following specific types of information: _____

_____

This consent shall expire: _____
(date)

I understand I have a right to receive a copy of this authorization upon my request.
Copy requested and received: Yes _____ No _____ Initials _____
A copy of this consent is just as valid as an original.

_____ _____
Patient signature (date)

_____ _____
Witness name and title Parent, guardian or authorized representative of patient

PROHIBITION ON REDISCLOSURE: This information is being disclosed to you from records which confidentiality is protected by federal law. Federal regulations (42CFR part 2) prohibit you from making any further disclosure of this information except with a specific written consent of the person to whom it pertains.

County of Santa Cruz

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 EMELINE AVENUE, SANTA CRUZ, CA 95061-0962

SANTA CRUZ HEALTH CENTER
1080 EMELINE AVE.
SANTA CRUZ, CA 95060
(831) 454-4100 FAX (831) 454-4296

WATSONVILLE HEALTH CENTER
1430 FREEDOM BLVD.
WATSONVILLE, CA 95076
(831) 763-8400 FAX (831) 763-8237

TDD: (831) 454-4123

DIVISIÓN MÉDICA AMBULATORIA

Autorización para liberar información de su historia médica

Yo, _____

por la presente autorizo

_____
_____
_____

(nombre y dirección de la persona u organización)

el suministro a

_____
_____
_____

(nombre y dirección de la persona u organización)

cualquiera y toda información médica obtenida durante el curso de mi tratamiento y diagnóstico, los cuales tengan alguna pertinencia a, y puedan incluir la mención de abuso, de alcohol y/o de drogas, enfermedad psiquiátrica, HIV+, el complejo relacionado al SIDA (ARC), y/o Síndrome de Inmune Deficiencia Adquirida (SIDA), referente a:

_____
(Nombre del paciente) (Numero de seguridad social del paciente)

_____
(fecha de nacimiento) (Numero dé historia medico del paciente)

Esta revelación de información médica es necesaria para los siguientes propósitos:

_____

Esta revelación de datos estará limitada a los siguientes tipos de información especifica:

_____

Este consentimiento se vencerá: _____
(fecha)

Si la solicito, entiendo que tengo el derecho de recibir una copia de esta autorización.

Copia solicitada y recibida: Si_____ No_____ Iniciales_____

Una copia de esta planilla de consentimiento es tan valido como la original.

_____
Firma del paciente (fecha)

_____
Testigo (nombre y titulo) Padre, guardián o representante autorizado del paciente

PROHIBICIÓN DE SU RE-REVELACION: Esta información se le esta siendo revelada de una fuente de datos que está confidencialmente protegida bajo la ley federal. La regulación federal (42CFR parte 2) le prohibe hacer revelación adicional de esta información, sin tener el consentimiento por escrito de la persona de la cual se trata.

COUNTY OF SANTA CRUZ Human Services Department

AUTHORIZATION FOR RELEASE OF INFORMATION
AUTHORIZED REPRESENTATIVE

Case Name:
Case Number:
Worker Name: Phone Service Center
Worker Number: BCCW
Worker Telephone: (888) 421-8080
Date:

Welfare and Institutions Code 10850.2 provides, in part, that "...records...of any public assistance programs shall be open for inspection by the recipient to which the information relates, and by any person authorized in writing by such recipient. **The written authorization shall be dated and signed by such recipient and shall expire one year from the date of execution."**

I, _____, residing at _____
APPLICANT/CLIENT NAME STREET ADDRESS

_____, do hereby authorize the person(s) listed below to act as my
CITY/STATE/ZIP CODE

representative in the matters regarding my case. You are hereby authorized to release and discuss all information regarding my _____ eligibility.

My authorized representative is:

_____ _____ _____
NAME OF AUTHORIZED REPRESENTATIVE PHONE NUMBER RELATIONSHIP TO APPLICANT/CLIENT

_____
ADDRESS OF AUTHORIZED REPRESENTATIVE

_____ _____ _____
NAME OF AUTHORIZED REPRESENTATIVE PHONE NUMBER RELATIONSHIP TO APPLICANT/CLIENT

_____
ADDRESS OF AUTHORIZED REPRESENTATIVE

Client Signature: _____ Date: _____

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA Palo Alto Health Care System
3801 Miranda Ave.
Palo Alto, CA 94304

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Santa Cruz Veterans Court (701 Ocean St, Santa Cruz, CA 95060), all affiliated individuals, agencies, attorneys, and court evaluator - see attached listing.

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☒ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: All drug tox screens as deemed relevant by the court
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: All relevant medical record information needed for court supervision

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Upon completion of court program

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*

LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

Veterans Justice Outreach (VJO) Specialist will provide summary of progress via written, verbal, telephonic and/or secured email that is required by court to determine program eligibility and for monitoring of patient progress in treatment and compliance with legal conditions of Veteran Treatment Court participation, inclusive of all relevant medical record information both past and future. Information will include but not be limited to: diagnoses (medical, mental health, and substance/alcohol), relevant labs, medical diagnoses, progress in treatment programming, developmental, social, financial and military data as relevant to court/legal circumstances to the designated court team and additional guests as permitted by authorization. Information will be shared with the home court to determine eligibility as needed and at regular intervals by the Court Team in Veterans Court to adequately assess progress of Veteran and compliance with court and probation guidelines. The authorization will expire upon Veteran discharge or successful completion of court program and probation period which may last longer than the court program. Medical record information is subject to review in open court docket. Affiliated parties include public defenders, district attorneys, probation officers, peer mentors, veterans service officer, veterans service advocate, court coordinator, MENtors program staff, and judges.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2024

REQUEST PERTAINING TO MILITARY RECORDS

Requests can be submitted online using eVetRecs at https://www.archives.gov/veterans/military-service-records/

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE				☐	☐	
b. RESERVE				☐	☐	
c. NATIONAL GUARD				☐	☐	

6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN: 1. _____ 2. _____ 3. _____ 4. _____

7. IS THIS PERSON DECEASED? ☐ **NO** ☐ **YES** - ***MUST*** *provide Date of Death if veteran is deceased:* _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ **NO** ☐ **YES**

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation): _____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.
☐ I request inpatient/hospitalization records from _____ (facility), last treated in _____ (year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

2. PURPOSE: (Providing information about the purpose of the request is **voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. RELATIONSHIP TO VETERAN: _____

3. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)

☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)

☐ OTHER (Specify): _____

4. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Xavier Bianchi Veteran Advocate Santa Cruz County
Name

842 Front St. _____
Street Address Apt. #

Santa Cruz CA 95060
City State ZIP Code

831-281-0388 831-458-7116
Daytime Phone Fax Number

xavier.bianchi@santacruzcountyca.gov
Email Address

5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

_____ _____
Signature Required – Do not print **Date**

* This form is available at https://www.archives.gov/veterans/military-service-records/standard-form-180.html on the National Archives and Records Administration (NARA) website. *

SANTA CRUZ COUNTY PROBATION DEPARTMENT
FERNANDO GIRALDO, CHIEF PROBATION OFFICER
MAILING: P.O. BOX 1812, SANTA CRUZ, CA 95061
PH: (831) 454-2150 FAX (831) 454-3327 / PH: (831) 763-8070 FAX: (831) 763-8233

"A Safe and Thriving Community with Justice for All"

Authorization for Use, Exchange, and/or Discharge of Confidential Information

Purpose of disclosure: To help assess and determine progress and compliance while under supervision.

☐ General Release *Signature*: _____

***General Consent*:** This consent remains in effect until my evaluation for or participation in services. Recipients of this information may re-disclose and use this information only in connection with their official duties.

Check all that apply: ☐ ALL

☐ Barrios Unidos	☐ Encompass	☐ Janus	☐ Positive Discipline
☐ County Office of Educ.	☐ First 5 Santa Cruz County	☐ Leaders in Community Alt.	☐ Sobriety Works
☐ Collaborative Court	☐ Goodwill	☐ Mentors	☐ Streets to Schools
☐ Conflict Resolution Center	☐ Hope Services	☐ Monarch Services	☐ Volunteer Center
	☐ Health Services Agency	☐ New Life Community Svc.	☐ _____

☐ Mental Health (MH)/Medical *Signature*: _____

***For Mental Health/Medical Consent*:** A recipient of medical information pursuant to this authorization may not further disclose the medical information except in accordance with a new authorization that meets the requirements of California Health and Safety Code section 56.11, or as specifically required or permitted by law.

Check all that apply: ☐ ALL

☐ Barrios Unidos	☐ Encompass	☐ Janus	☐ Positive Discipline
☐ County Office of Educ.	☐ First 5 Santa Cruz County	☐ Leaders in Community Alt.	☐ Sobriety Works
☐ Collaborative Court	☐ Goodwill	☐ Mentors	☐ Streets to Schools
☐ Conflict Resolution Center	☐ Hope Services	☐ Monarch Services	☐ Volunteer Center
	☐ Health Services Agency	☐ New Life Community Svc.	☐ Other: _____

☐ Substance Use Disorder (SUD) *Signature*: _____

***For Substance Use Disorder Consent*:** Substance use disorder records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Check all that apply: ☐ ALL

☐ Barrios Unidos	☐ Encompass	☐ Janus	☐ Positive Discipline
☐ County Office of Educ.	☐ First 5 Santa Cruz County	☐ Leaders in Community Alt.	☐ Sobriety Works
☐ Collaborative Court	☐ Goodwill	☐ Mentors	☐ Streets to Schools
☐ Conflict Resolution Center	☐ Hope Services	☐ Monarch Services	☐ Volunteer Center
	☐ Health Services Agency	☐ New Life Community Svc.	☐ Other: _____

I, _____, _____
(Print name of client or client's representative) (Print date of birth)

hereby authorize the Santa Cruz County Probation Department to disclose and receive confidential information contained in their file to the agencies indicated above.

I understand that any of this information may be used by the Probation Officer in any report to the Court and, therefore, be available to the District Attorney and my attorney.

I may revoke my consent verbally or in writing at any time (except to the extent that action has already been taken), and if not earlier revoked, it shall terminate one year from today on (date): _____.

Signature: _____ Date: _____
Signature of client or client's representative

Witnessed by: _____
Signature

Legal relationship of above signer: _____

Date: _____