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. 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: _____