Mental Health Diversion Court

APPLICATION FOR PARTICIPATION

FILL TIDS FORM OUT WITH YOUR ATTORNEY

Medical Records must be submitted within 5 Days ofCDA's Preliminary Approval to be considered for final approval with MHDC

ONCE THIS FORM IS COMPLETELY FILLED OUT, YOU MAY EITHER:

Email this completed form to: mentalhealth-diversion@tarrantcountytx.gov

Defendant Name: _____ _____ _____ _____
First Middle Last Email Address

Home Address: _____ _____ _____ _____ _____
Number and Street Name Apt# City State Zip Code

Two phone numbers where you may be reached: #1 :_____ and #2: _____

Any Previous Aliases/Maiden Names:_____ Date of Birth: _____

Tarrant County Case Number(s):_____ Tarrant County CID Number: _____

Diagnosis and Age of Onset: _____

Prior to this program, has applicant participated in anyotherdiversion programs *(circle one):* Yes or No

Briefly explain in the space below why you want to participate in the Mental Health Diversion Court. **(Make sure you do not state any facts of your alleged offense. Until you are accepted into the Mental Health Diversion Court, these statements could be used against you).**

_____

_____

_____

_____

I certify the above information is accurate. I have reviewed this document with my attorney, and I wish to be considered for participation in the Mental Health Diversion Court.

_____ _____
Defendant Signature Attorney Signature

_____ _____ _____
Attorney Name Attorney Contact Number Attorney Email Address

_____
Date Submitted

Tarrant County Mental Health Diversion Program
Intake Questionnaire

Background Information			
First Name:	Last Name:		Today's Date:
Date of Birth:	Age:		Gender:
Email Address:	Cell Phone Number:		Home Phone Number:
Attorney:		Attorney's Phone Number:	
Emergency Contact Name & Relationship to You:		Emergency Contact Phone Number:	
Do you have a valid driver's license?		Do you have reliable transportation?	
Online: Do you have access to Skype? Yes No	Online: Do you have access to Microsoft Go To Meeting? Yes No	Online: Do you have access to Zoom? Yes No	Do you have a smart phone? Yes No
Are you a U.S. Citizen?	If not a citizen, do you have legal documents?	Primary Language:	

Residence			
Current Address:	City:	State:	Zip Code:
How long have you lived there?	Who do you live with and relationship to self?		

Education			
Did you graduate high school or complete GED? Yes - HSD Yes - GED No - Did not complete	High School:	Year of Completion:	Highest Grade Completed:
Were you previously enrolled in special education classes? Yes No	Are you currently in school? Yes No	Highest Level of Education:	
College or Technical School/Degree/Certifications:		Year of Completion:	

Tarrant County Mental Health Diversion Program
Intake Questionnaire

Employment		
Current Employer:	How many hours do you work per week?	Job Position:
How long have you been employed there?	Average Monthly Income:	Household Average Monthly Income:
Do you receive any other income? If yes, amount:	Do you have health insurance? If yes, what kind: Yes No Insurance: _____	Military History: Reason for Discharge:

Family		
Marital Status:	Length of Current Relationship Status?	Spouse Name:
Number of Children?	Do your children live with you? Yes No	If not, with whom?
Are you required to pay child support? Yes No	If so, how much?	

Substance Abuse History			
Have you ever used any of the following substances?	Circle	Age of First Use	Date of Last Use
Alcohol	Yes No		
Heroin	Yes No		
Methadone	Yes No		
Opiates/Analgesics/Pain Pills	Yes No		
Benzodiazepines (Xanax, Klonopin, etc.)	Yes No		
Cocaine	Yes No		
Amphetamines/Methamphetamines	Yes No		
Marijuana	Yes No		
Hallucinogens	Yes No		
Inhalants	Yes No		
Have you ever attended substance abuse treatment? If so, where and when.: _____ _____ _____ _____			

Tarrant County Mental Health Diversion Program
Intake Questionnaire

Mental Health

Have you ever attended treatment for ***mental health?*** Yes No
If yes, what is your ***diagnosis?*** _____
If yes, *please list below. Include previous hospitals such as JPS, Mesa Springs, Millwood, any previous outpatient programs such as PHP and /OP, Psychiatrist, Primary Doctor, MHMR, Counselors/Therapist, etc.*

Where (List Below}	When (Most Recent First}	What For

Are you currently prescribed ***mental health*** medications? Yes No
If yes, please list medication below, with prescribed dosage/Frequency and prescribing physician.

Medication	Dosage/Frequency	Prescribing Physician

Is there anything else that you would like for us to know about you? If so, please discuss:

_____

_____

_____

_____

Mental Health Diversion Court

INFORMED CONSENT FOR INTERVIEW AND PERMISSION TO RELEASE INFORMATION

The goals of the Tarrant County Mental Health Diversion Court (MHDC) are consistent with the Texas Government Code § 125.001, to provide diversion of potentially mentally ill or intellectual and developmentally disabled defendants to needed services as an alternative to subjecting those defendants to the criminal justice system. If you successfully complete the program your charges will be dismissed.

I, the undersigned understand that a mental health professional is interviewing me to help determine if I preliminarily meet the clinical criteria for admission into the Mental Health Diversion Court. I understand that this interview does not mean I am accepted into the program and as such, I am required to follow all current bonds, pretrial or court ordered conditions. I hereby consent to the interview as described above and give my permission for information gathered during this interview, and other sources to be shared with the members of the Mental Health Diversion Court Team which includes but is not limited to: other mental health professionals for consultation and training purposes, criminal defense attorneys, prosecutors and other criminal justice/court staff and personnel as outlined in Sec. 125.003. By signing this document, I understand I am waiving my legal rights to confidentiality to allow judicial efficiency due to my current pending case(s).

I agree to meet with my attorney to discuss the conditions of the MHDC to ensure I am making an informed decision to enter the program before I sign any required legal documents. I understand that admission to this program is voluntary and that the final approval for admission will be determined by a representative of the District Attorney's office and the Judge of the Mental Health Diversion Court.

Printed Name: _____

Applicant Signature: _____

Witness: _____

Date: _____

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entitties as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

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

PHONE (___) ___ **ALT. PHONE** (___) _____

EMAIL ADDRESS (Optional) : _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (___) _____ Fax (___) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Mental Health Diversion Court
Address: 401 W. Belknap City Fort Worth State TX Zip Code 76196
Phone 817-212-6805 Email: Mentalhealth-Diversion@tarrantcountytx.gov
(please email records or email for CD pickup)

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☒ **Legal Purposes**
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☒ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _ Day ___ Year ____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

mhmrtarrant
WE CHANGE LIVES

MHMR Case #: _____
Name: _____
Date of Birth: _____
SS #: _____
Medicaid #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request that:

Name: MHMR Tarrant County
Address: 3840 Hulen Street, Suite 126
City, State, Zip: Fort Worth Texas 76107
Phone: 817-569- 4410, 4417, 4153, 4257 **Fax/**
Email: 817-810-3600 health.information@mhmrtc.org

Provide to / Receive from:

Name: Mental Health Diversion Program
Address: 401 W. Belknap
City, State, Zip: Fort Worth, TX 76196
Phone: 817-212-6805
Email: mentalhealth-diversion@tarrantcountytx.gov

the following information which is limited to: *(Specify types of reports, type of communication requested)*

Psychiatric Evaluation, Medical, Progress Notes, Diagnosis and Drug/Alcohol

for the period of: (*Dates of treatment / period of time)* _____

Purpose or use of disclosure: _____

I authorize this information to be released in written and verbal form. If I am signing as a parent of a minor or guardian of a minor child, I further understand the record released may contain references to myself and family.

I understand my individually identifiable health information may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results medical history, treatment, or any such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form, unless I am receiving chemical dependency services. MHMR Tarrant may withhold treatment if I refuse to sign an authorization to disclose information necessary for the payment of chemical dependency services.

I understand that I may revoke this authorization at any time by notifying MHMR Tarrant, Health Information Management Department, in writing at 3840 Hulen Street, Suite 126, Fort Worth, Texas 76107. The revocation will not affect any actions taken before the receipt of the written revocation.

This authorization will expire one year from the date of this authorization unless I otherwise specify. This authorization expires: _____ *(not to exceed one year).*

Note: if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations. However, if you are receiving services for chemical dependency (drug or alcohol use), information about those services is protected from redisclosure by federal and state laws.

Individual Signature / Representative: _____ Date: _____

Legally Authorized Representative's Relationship to Individual: _____

Witness: _____ Date: _____

Rev. 08/23
L-002

A photocopy or facsimile of this authorization is as valid as the original.

AUTHORIZATION OF RELEASE OF INFORMATION

Consent to Release/Obtain PHI

Tarrant County Hospital District 1500 South Main ST Fort Worth, TX 76104 (JPS Medical Records Request)	Name: DOB: CID#: HOUSING:

JPS

1. I hereby authorize _____
(PHYSICIAN, HOSPITAL, SCHOOL, ETC.)

1500 SOUTH MAIN STREET FORT WORTH, TX 76104

(STREET ADDRESS) (CITY) (STATE) (ZIP)

2. To release information from my medical, educational, psychiatric/drug/alcohol records

SPECIFICALLY:
_____ History
_____ Discharge Summary
_____ Operative Report
_____ Physicians Orders
_____ Physician Progress Notes
_____ Nursing
_____ Radiology
_____ Social Services: Note: _____
_____ Other: Please Specify: _____
_____ EEG/EKG/Cat Scan
_____ Laboratory

3. From the time period of _____ to _____

4. For the following purpose: _____

5. This information may be released to: _____
(PHYSICIAN, HOSPITAL, SCHOOL, ETC.)

_____
(STREET ADDRESS (CITY) (STATE) (ZIP)

6. I understand that the specific type of information to be disclosed may include a history of drug or alcohol or mental health treatment or a communicable disease. (AIDS, HIV history, Hepatitis, etc.)

7. I expressly understand and agree that no legal responsibility of any nature shall attach to the attending physician or employee in acting upon this authorization.

8. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 90 days after the date of patient discharge, unless another date is specified:

Specification of date or event upon which this consent expires _____

9. A photocopy or facsimile of this authorization shall be as effective as the original.

_____ DATE

_____ SIGNATURE OF PATIENT

_____ PATIENT'S FULL NAME

_____ SIGNATURE OF SPOUSE, PARENT OR GUARDIAN

_____ DATE OF BIRTH

_____ UNIT RECORD NUMBER

☐ MALE ☐ FEMALE

_____ RELATIONSHIP

_____ SIGNATURE OF WITNESS

PROHIBITION ON REDISCLOSURE: This information is being disclosed to you from records whose confidentiality is protected by federal law. Further disclosure of this information except with the specific written consent of the patient is prohibited.