

**MONROE COUNTY MENTAL HEALTH TREATMENT REVIEW TEAM**

The Justice Building, 301 North College Avenue, Room 211  
Bloomington, Indiana 47404-3865  
(812) 349-2670

**CONSENT TO RELEASE / OBTAIN / DISCUSS CONFIDENTIAL INFORMATION**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**DEFENDANT / CLIENT ADVISEMENT**

Cases/charges pending against you are being considered for alternative resolution by the Monroe County Mental Health Treatment Review Team. You must understand that those named on this release will need to discuss your case and treatment history to facilitate consideration.

**TEAM MEMBERS**

**Permission To Discuss Records** - I hereby consent to communication between the Monroe County Mental Health Treatment Review Team members listed below. TEAM MEMBERS:

1. Monroe County Prosecuting Attorney or his designee, Deputy Prosecuting Attorney.
2. Monroe County Public Defender or his designee, Deputy Public Defender.
3. Monroe Circuit Court Probation Department. The Probation Department includes: the Adult Division, Juvenile Division, Community Corrections Program, Court Alcohol and Drug Program, and Drug Court.
4. Centerstone
5. Monroe County Jail Diversion Coordinator
6. Monroe County Correctional Center.
7. Other

The purpose of and need for the disclosure is to inform the Monroe County Mental Health Treatment Review Team members listed above of my potential appropriateness for an alternative resolution program. Information to be disclosed and discussed between the Monroe County Mental Health Treatment Review Team members listed above includes:

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| 1. Assessment/Diagnosis/Psychiatric Evaluation    | 5. Past and current medications                        |
| 2. Past/current treatment attendance and progress | 6. Past and present treatment plans                    |
| 3. Prognosis                                      | 7. Past and current discharge plans                    |
| 4. Probation records and treatment records        | 8. Lab results, including drug/alcohol tests, HIV/AIDS |

I understand that my treatment and probation records are protected under state and federal confidentiality statutes and/or regulations. I also understand that any disclosure made between the above named agencies or individuals is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records. Recipients of this information may re-disclose it only in connection with their official duties. I further understand that these records will not be disclosed without my written consent unless otherwise allowed by state or federal statute, rule or regulation. I understand that I may revoke this consent at any time in writing, except where there has been action taken in reliance upon this release. Should I wish to revoke this release, I understand that a revocation should be in writing and delivered to my attorney, or if I am not represented by an attorney, to any Team Member listed above. In the absence of such written revocation, this consent will expire either upon determination that I am not appropriate for an alternative resolution, or in 180 days, whichever should occur first.

I further understand that by executing this release, no representation, either expressed or implied, has been made regarding whether I will or will not be accepted into an alternative resolution program. By executing this release, I expressly agree that those named above in the box labeled "Team Members" will be able to discuss any and all aspects of my current charges, criminal history, educational history, and treatment history (mental health and/or medical) while making a determination as to whether I would be appropriate for an alternative resolution program. It is agreed that these records and any information from these records or from any individual (excepting those dealing with current charges pending against me) will not be used against me in a court of law.

\_\_\_\_\_  
**Date**

**X**  
\_\_\_\_\_  
**Defendant/Client Signature**

Signature of: ( ) Client ( ) Parent ( ) Guardian or Legal Representative (proof required)