Superior Court of Cobb County
Mental Health Court

APPLICATION INSTRUCTIONS

1) Review with the defendant the program eligibility requirements (please see Judicial Council of Georgia's "Standard for Accountability Courts §2.3" concerning defense counsel). In order to participate in this program, the defendant must:
    a. Have been diagnosed with a mental illness prior to his or her arrest or during his or her incarceration for the present charge.
    b. Be competent to enter a plea of guilty.
    c. Have, or be able to obtain, stable housing and transportation in Cobb County.

2) Complete and sign all documents included in this packet. If the case has been indicted or accused, ***you must include the Indictment/Accusation number on each applicable document.*** If the case has not been indicted or accused, ***you must include the warrant number.*** Do not include any other identifying numbers, such as the police complaint number.

3) File the "PETITION TO PARTICIPATE IN MENTAL HEALTH COURT" form with the Clerk of Superior Court, if the case has been indicted or accused. If there is no indictment or accusation, the petition may remain with this packet.

4) Return all remaining documents to the District Attorney's Director of Accountability Courts for further review.

5) Upon notification of defendant's acceptance into the program, arrange to schedule defendant's plea submission.
    a. Those defendants eligible to participate on a pre-adjudication basis (who have no prior felony convictions) will plead guilty but sentence will be withheld. Upon successful completion the plea will be withdrawn and a Nolle Prosequi order entered.
    b. Those defendants with prior felony convictions will plead guilty and be sentenced, with participation in this program made a special condition.

After thoroughly reading these instructions, if you have any questions please call the District Attorney's Director of Accountability Courts at 770-528-3080. The enclosed documents may be amended or supplemented at any time in the discretion of the Mental Health Court team, therefore a new packet must be obtained by visiting **www.cobbda.com** for each defendant. ***Copies should not be kept for future use.***

IN THE SUPERIOR COURT OF COBB COUNTY
MENTAL HEALTH COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

PETITION TO PARTICIPATE IN MENTAL HEALTH COURT

Comes now, _____, Defendant charged in the above styled case and shows the court the following:

The Defendant is charged with the offense of _____. Prior to or contemporaneous with this charge, the defendant has been diagnosed with a specific mental illness, and states that this illness is a significant and relevant part of the above-styled case.

The Defendant has been advised of the requirements of the Cobb County Superior Court's Mental Health Court Program and is able and willing to meet all criteria necessary to enter said program.

The Defendant has been advised of his/her Constitutional Rights by the undersigned attorney, and understands the requirement to waive certain of these rights in order to enter the program. The Defendant further understands that, should he/she not be accepted in the Mental Health Court Program for any reason, the case will be returned to the normal criminal justice system.

Wherefore, Defendant prays that the Court allow this defendant's participation in said Mental Health Court Program.

_____ _____
Attorney for Defendant Print name

Address:

_____ Telephone No. (____) _____

_____ Fax No. (____) _____

_____ email _____

IN THE SUPERIOR COURT OF COBB COUNTY
MENTAL HEALTH COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

MENTAL HEALTH COURT CONTRACT

I, _____, understand that the validity of this agreement is conditioned upon my eligibility for the Mental Health Court Program. If at any time after the execution of this agreement it is discovered that I am ineligible to participate in the program, I may be immediately terminated from the program. In consideration of the agreement by the State to allow participation in this program in lieu of traditional prosecution of my charged offense(s), I hereby agree to the following (*please initial each*):

1. _____ I will complete each and every aspect of the Mental Health Program, which I understand involves a time commitment of eighteen (18) to twenty-four (24) months and which may be extended indefinitely due to treatment compliance or other factors.

2. _____ I understand that I must complete mental health treatment based on my particular needs and diagnosis. I will cooperate in an assessment/evaluation for planning an individualized treatment program. I understand that my treatment plan may be modified by the treatment providers or the Mental Health Court team as circumstances arise, and I agree to comply with the requirements of any such modifications.

3. _____ I will comply with the policies, procedures, and instructions of staff members of Mental Health Court and the Community Services Board, including treatment providers at any assigned mental health treatment facility.

4. _____ I will take any and all medication as prescribed by a physician or psychiatrist. I will report any difficulties taking medication (side effects, etc.) to the physician or psychiatrist immediately.

5. _____ I will keep the Mental Health Court team advised of all medications I am prescribed, and will immediately report any change in status. I will execute any release necessary to allow said team to gain information about my medications from my physician, psychiatrist, or pharmacist.

6. _____ I will inform any physician, psychiatrist, or pharmacist from who I seek any advice or treatment that I am a participant in Mental Health Court.

7._____ I will not possess, use, or ingest any drug, alcohol, or any substance which is designed to alter perception or mood, unless lawfully prescribed and approved by Mental Health Court staff, regardless of whether it is legal to possess or use such substance. I will not associate with people who use or possess such substances, nor will I knowingly be present while drugs, alcohol, or other such substances are being used by others.

8._____ I will submit to testing for the presence of illegal or non-prescribed drugs, alcohol, and perception or mood altering substances in my system on a random basis according to procedures established by the Mental Health Court team and/or treatment provider. I understand that I will be given a location and time to report for my drug test. I understand that it is my responsibility to report to the assigned location at the time given.

9._____ I will not substitute, alter or try in any way to change my body fluids for purposes of testing.

10._____ I will submit to a drug or alcohol test at any time, by any police officer, treatment provider, Mental Health Court staff member, or at the request of the Court or any agency designated by the Court.

11._____ I will avoid persons and places of disreputable or harmful character or knowingly associating with persons who violate the law.

12._____ I will not violate the laws of any governmental unit during my participation in this program.

13._____ I will inform any law enforcement officer with whom I come in contact that I am a participant in Mental Health Court, and will immediately report to Mental Health Court if I am arrested or issued a citation for any criminal offense by any law enforcement agency.

14._____ I will not possess any weapons while I am in Mental Health Court. I will dispose of any and all weapons in my possession, and disclose the presence of any weapons possessed by anyone else in my household.

15._____ I will maintain a stable residence within Cobb County at all times during my participation in this program. I will keep the Mental Health Court team advised of my current address, telephone number, and employment or school status, and will immediately report any change in status.

16._____ I will not leave the State of Georgia at any time, or stay overnight at a location other than my approved residence, during the course of the program without the prior permission of the Mental Health Court staff.

17._____ I agree that if, in the reasonable opinion of a member of the Mental Health Court team or a treatment provider, I exhibit behaviors indicating a risk of harm to myself or others, the proper authorities and my next of kin may be notified of such behavior. I hereby waive any right of confidentiality I may have in such information under such circumstances.

18. _____ I understand that any right I may have to request that my criminal history record be restricted (what is commonly known as "expungement") will be governed solely by O.C.G.A. §35-3-37, and that any request for such restriction must be filed in a separate proceeding. Nothing in this agreement shall guarantee any restriction on my criminal record, or limit my right to seek such restriction as allowed by law.

19. _____ I understand that this agreement is subject to future revisions, additions, and/or amendments, and that should my consent to such revision, addition, or amendment be required during my participation in this program, I will have the right to seek the advice of counsel.

I have read the above contract, or had it read to me, and I acknowledge that I understand all of its terms and conditions. **I understand that failure to comply with any of the conditions herein may result in a sanction up to and including termination from the program.** I have been given the opportunity to ask any questions which I may have. I hereby voluntarily enter into this agreement with the Cobb County Superior Court Mental Health Court Program.

_____ _____
Defendant's Signature Date

_____ _____
Attorney for Defendant Date

_____ _____
Assistant District Attorney Date

_____ _____
Mental Health Court Judge Date

TO BE COMPLETED BY DEFENSE COUNSEL *(please initial each)*:

_____ I have explained the above information, along with the other application materials, to the defendant. I have explained the constitutional rights which the defendant hereby waives by submitting these materials.

_____ I believe that the defendant understands his/her constitutional rights and the consequences of entering this agreement.

_____ I believe (to the best of my professional knowledge and without rendering a medical opinion) that the defendant is competent to enter this agreement and does so freely and voluntarily.

Superior Court of Cobb County
Mental Health Court

PROGRAM PARTICIPANT INFORMATION

Personal Information

Case Number: _____ Date: _____

Name_____D.O.B._____

Address_____
Street Apt# City State ZIP

County of Residence_____

Social Security # _____-____-_____ Telephone: (_____) _____-_____

Marital Status _____

Children (number and ages) _____

Contact in case of Emergency_____
Name Relationship

Telephone: (Home): (_____)_____-_____ (Other): (_____)_____-_____

Employment

Employer_____

Address_____
Street Apt# City State ZIP

Telephone: (_____) _____-_____ Immediate Supervisor _____

Insurance Information

☐ Medicare ☐ Medicaid ☐ medication assistance (provide detail below)

Private provider: _____

Other: _____

Superior Court of Cobb County
Mental Health Court

PROGRAM PARTICIPANT INFORMATION

References

Defendant Name: _____ Case No.: _____

Provide the requested information for at least 2 people who Mental Health Court staff may contact to verify the information contained in this application or to seek additional information. If Defendant will live with another person during participation in this program, that person must be included here.

Reference #1_____
Name Relationship

Address_____
Street Apt# City State ZIP

Telephone: (_____) _____-_____ If defendant lives with this person check here ☐

Reference #2_____
Name Relationship

Address_____
Street Apt# City State ZIP

Telephone: (_____) _____-_____ If defendant lives with this person check here ☐

Reference #3_____
Name Relationship

Address_____
Street Apt# City State ZIP

Telephone: (_____) _____-_____ If defendant lives with this person check here ☐

I hereby give permission for Mental Health Court or Community Service Board staff members to contact the above individuals. I waive any right of confidentiality which may exist and I consent to these individuals discussing my living arrangements, mental health status, criminal charges, and any other information which may aid in assessing my eligibility for this program.

_____ _____
Defendant's Signature Date

Superior Court of Cobb County
Mental Health Court

MEMORANDUM OF UNDERSTANDING CONCERNING ATTORNEY-CLIENT RELATIONSHIP IN MENTAL HEALTH COURT

I, _____, having requested to participate in the Cobb County Mental Health Court Program, understand that decisions concerning the administration of this program are made by a multi-disciplinary team which may include program administrators, treatment providers, probation officers, and attorneys representing both prosecution and defense, under the direction of the Mental Health Court judge. While attorneys, including prosecutors, take part in this process, the program does not operate under the traditional adversarial model of other court proceedings. Because of this, I understand and agree to the following:

1) Prior to my acceptance into the Mental Health Court Program, I have the right to be represented by an attorney, either one chosen and retained by me or one appointed by the Cobb County Circuit Defender's Office. This attorney can advise me, among other things, as to whether the Mental Health Court Program is an appropriate and beneficial alternative to the traditional criminal litigation process in my particular case.

2) After my acceptance into the Mental Health Court Program, the administrator of the Cobb County Circuit Defender's Office, or his designee, will act as the defense representative on the Mental Health Court Team. I will no longer have the right to have my previous attorney advise me regarding the decisions made by this team, including the imposition of sanctions where appropriate.

3) During my participation in this Program, the defense representative will act not as my attorney in the traditional sense, but as a member of the Mental Health Court team. As such, he or she will join in discussions and decisions regarding my participation in the program including, but not limited to, my advancement or non-advancement through the phases of the program and the imposition of sanctions for violations of the program's rules or contract.

4) The duties of the defense representative as a member of the Mental Health Court team may not be in my best interest if I have violated any provision of the Mental Health Court Program's rules or contract.

5) I will not have the right to have an attorney represent me individually at court appearances during my participation in the Mental Health Court Program or before the Mental Health Court team, even if the Court is considering whether to impose a sanction. Mental Health Court proceedings are not "critical stages of litigation" and therefore I do not have a right to be represented by an attorney during these proceedings. I understand that my case may be discussed, and sanctions (including incarceration) may be imposed, without my attorney or the prosecutor present.

6) Should the Mental Health Court team decide to recommend that the Court terminate my participation in the program due to a violation or violations of the program's rules or contract, I will be entitled to be represented by an attorney, either one chosen and retained by me or one appointed by the Cobb County Circuit Defender's Office. This attorney may then represent me individually in termination proceedings and in any subsequent litigation involving the disposition of my case outside the Mental Health Court Program.

I have read this document or had it read to me and have been given the opportunity to ask any questions I may have. I have been given the opportunity to discuss this document with my attorney and have sought his or her advice as to whether Mental Health Court would be beneficial for me, and I wish to be considered for participation in this program.

This the _____ day of _____, 20____.

_____ _____

Defendant Print name

_____ _____

Attorney for Defendant Print name

Superior Court of Cobb County
Mental Health Court

CRIMINAL HISTORY CONSENT FORM

I hereby authorize the Cobb County Mental Health Court and/or Cobb County Sheriff's Office to receive any criminal history record information pertaining to me which may be in the files of any criminal justice agency of any state, or any local criminal justice agency in the state of Georgia. This authorization shall be effective at any time during my participation in the Mental Health Court program as well as at intervals of one, two, and five years after my completion of the program. I further give consent to the Mental Health Court team to view my juvenile criminal history for the purpose of assessment only. I understand that these records can not be used against me as an adult.

_____
Full name printed

_____
Address

_____ _____ _____
City State Zip Code

_____ _____ _____ _____
Sex Race DOB Social Security Number

_____ _____
Drivers' License Number State

_____
Participant's Signature

IN THE SUPERIOR COURT OF COBB COUNTY
MENTAL HEALTH COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

WAIVER OF RIGHT TO ASSERT SPECIFIED GROUNDS

AS A BASIS FOR MOTION OF RECUSAL

The defendant, and his or her counsel, hereby acknowledge that as consideration for acceptance and/or continued participation in the Cobb County Mental Health Court Program:

1. That the above-styled case will be assigned to the Mental Health Court division of Superior Court, and a designated elected, senior, or assisting Superior Court judge will sit as the Mental Health Court judge;
2. That the Mental Health Court judge will preside over any termination hearings, should consideration of termination arise prior to graduation; and
3. That should defendant fail to successfully complete the Mental Health Court Program and be terminated from said program, disposition of the case may be decided by the designated Mental Health Court judge or may be referred to the previously-assigned judge.

Understanding that the assignment of this case may be to the designated Mental Health Court judge throughout all proceedings until ultimate disposition of the case, irrespective of defendant's success or failure in completing the Mental Health Court Program, the defendant hereby waives his or her right to assert, as a basis for a motion to recuse the Mental Health Court judge, any of the following:

1. The personal involvement of the Mental Health Court judges with the defendant during his or her participation in the Mental Health Court Program;
2. The Mental Health Court judges' knowledge, both personal and otherwise, of defendant's compliance or non-compliance with the requirements of the Mental Health Court Program; or
3. The Mental Health Court judge's decision to terminate the defendant from the Mental Health Court Program on the basis of his or her failure to comply with such requirements.

Defendant hereby freely, voluntarily and knowingly waives the right to assert the foregoing as grounds for a motion to recuse and acknowledges that he or she does so having consulted with counsel.

This ___ day of _____, 20____.

_____ _____

Defendant Attorney for Defendant

IN THE SUPERIOR COURT OF COBB COUNTY
MENTAL HEALTH COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

WAIVER OF RIGHTS

I, _____, understand that I am guaranteed by the United States and Georgia Constitutions the following rights:

1. A speedy trial;
2. A trial by jury;
3. The right to confront the witnesses against me;
4. The right not to incriminate myself or give any information which could be used against me,
5. The right to call witnesses and present evidence on my own behalf, and to use the power and process of the court to compel the attendance of such witnesses and evidence,
6. The right to have an attorney represent me at all stages of criminal process,

and that as a condition of acceptance into, and participation in, the Mental Health Court Program, I expressly waive (that is, give up) those rights.

I also understand that if I am not accepted in the program, my waiver of the rights listed above will also be withdrawn and I may petition the court for a speedy trial. Any statements given by me as part of the Mental Health Court assessment process will not be used against me.

This the _____day of _____, 20____.

_____ _____

Defendant Attorney for Defendant

IN THE SUPERIOR COURT OF COBB COUNTY
MENTAL HEALTH COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

WAIVER OF FOURTH AMENDMENT RIGHTS

I, _____, having requested to participate in the Cobb County Mental Health Court Program, and in consideration of the agreement by the State to allow such participation in lieu of traditional prosecution of my charged offense(s), hereby state the following:

I understand that I have rights that protect me from unreasonable search and seizure.

I understand that these rights are guaranteed by the Fourth Amendment to the United States Constitution, as well as the Constitution of the State of Georgia.

I also understand that I can voluntarily give up these rights as part of an agreement to provide an alternative to traditional prosecution or incarceration.

As a condition of my participation in the Mental Health Court Program, I agree to the search of my person, property, place of residence, vehicle or personal effects at any time with or without a warrant, and with or without reasonable cause, when required by a probation officer, treatment staff, Mental Health Court staff, and/or any law enforcement officer at any time during my participation in this program. I hereby give permission for such individuals to remove, forcibly if necessary, any locks or other hindrances which may prevent access to such places and property for the purpose of any such search. I consent to the use of any evidence seized during such a search in any prosecution that may arise from said search.

This the _____day of _____, 20____.

_____ _____

Defendant Attorney for Defendant

Superior Court of Cobb County
Mental Health Court

DRUG SCREEN POLICY

I understand that if I test positive for drugs or alcohol at the time of my assessment, it will not be held against me because this screen is used to help determine eligibility for the Mental Health Court Program. However, I understand and agree that if I use drugs and/or alcohol at any time after the assessment, even prior to my acceptance or orientation into the program, I will receive a sanction which may include jail or termination from the program. I agree to read and abide by the drug screening procedures explained in these materials or by any member of the Mental Health Court team.

I understand that if my urine drug screen indicates a positive result for any illegal or non-prescribed drug or alcohol, based on any testing method approved by the Court, at any time while in the program, I will receive a sanction. I understand that the Court will not conduct any evidentiary hearing to allow me to contest such a result and that I will not be allowed to submit any separate results from any other laboratory or testing process. I understand that I will be given the opportunity to request a confirmatory test at my own expense; however I also understand that *should such testing confirm the positive result my sanction will be increased.*

I understand that if I test positive on any alcohol and/or drug test, and the result is obtained while I am present at any court or treatment facility, then I will not be allowed to operate a motor vehicle. I will immediately surrender my automobile keys to staff and call someone for a ride home.

I understand that if I miss, or arrive more than 30 minutes late for, any scheduled drug screen, the test will be presumed to be positive. I understand that any sample which does not contain a sufficient volume of liquid for testing, or which is dilute (that is, which contains a concentration of creatinine less than 20 mg/dl), will be deemed inadequate for testing, and the test will be presumed to be positive. I further understand that, for any such presumed positive test, I will receive a sanction which may include incarceration or termination from the program.

_____ _____

Participant's Signature Date

_____

Print name

Superior Court of Cobb County
Mental Health Court

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, hereby consent to communication, within or outside my presence, regarding my medical, psychological, or substance abuse history among any of the following individuals: any physician, psychiatrist, or psychologist designated by the Mental Health Court treatment providers, the Mental Health Court judge, any prosecutor designated by the District Attorney, any attorney designated by me or by the Cobb County Circuit Defender's Office, any member of the Mental Health Court team, and any evaluator or counselor designated by the Mental Health Court treatment providers. I understand and agree that the purpose and need for this disclosure is to assist the Court in evaluating and determining my eligibility to participate in the Mental Health Court program as well as my prognosis, compliance and progress in accordance with Mental Health Court criteria. I hereby agree to hold such individuals harmless and relieve and release such individuals from any and all liability regarding any such communication.

This consent extends only to that communication which is necessary for and pertinent to hearings and/or reports concerning my specific Mental Health Court case. Recipients of this information may not re-disclose it except in connection with my Mental Health Court treatment and then only with my written consent, except as permitted by federal law and rules, including but not limited to bona fide medical emergencies, valid court orders, and when there is a suspicion of a danger to others (including suspicion of child abuse or neglect).

Any information obtained through this release is for the exclusive use of the individuals described above. All documents generated by this release shall be kept separate and apart from my court file.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Mental Health Court, and/or a formal discontinuation of court proceedings regarding my case.

_____ _____

Participant's Signature Date

_____

Print name

Superior Court of Cobb County
Mental Health Court

FRATERNIZATION RULES

I, _____, having requested to participate in the Cobb County Mental Health Court Program ("MHC"), understand and agree to the following:

1. "Mental health treatment participant", as used in this agreement, includes all MHC participants, regardless of phase, and also includes any other person with whom an MHC participant comes into contact as a result of any mental health treatment activity. This includes, but is not limited to, patients, providers, staff, and family members of any such people.
2. Social contact with any mental health treatment participant, or group of participants, of the opposite sex or same sexual orientation outside of treatment, court, or court-ordered activities is prohibited unless approved by a staff member or by the Court. This includes personal contact (one-on-one or in a group setting), phone contact, electronic or internet contact, written contact, and any other form of communication.
3. Any sexual involvement with any mental health treatment participant is prohibited under any circumstances.
4. Mental health treatment participants may not be employed by the same employer or work together, whether paid or unpaid, without court approval.
5. Mental health treatment participants may not provide transportation to any MHC participant unless approved by a staff member or by the Court.
6. Mental health treatment participants may not loan one another money, clothing or other personal items.
7. Mental health treatment participants may not perform work-related services for any other participant.

I have read this document or had it read to me and have been given the opportunity to ask any questions I may have. I hereby agree to abide by the above rules as a condition of my participation in the Mental Health Court Program. I understand that any violation of these rules may result in a sanction up to and including termination from the program.

_____ _____

Participant's Signature Date

_____

Print name

Superior Court of Cobb County
Mental Health Court

DISCHARGE POLICY

I understand that, once I have been accepted into this program, I will remain a participant in this program and be subject to all rules and requirements until I am discharged by the entry of a written order of the Mental Health Court judge, my completion of certain phase requirements or participation in exit interviews or completion ceremonies notwithstanding. I understand that a discharge order will only be entered in the event of: 1) successful completion of the program, 2) termination from the program by order of the Court, or 3) withdrawal by permission of the Mental Health Court judge. I understand that I will not at any time have the option to unilaterally withdraw from the program, even if I am facing a sanction.

I further understand that my graduation from this program will be contingent upon the results of a final urine drug screen which will be administered on the day of my scheduled completion. I understand that a positive result on this test may lead to a sanction, including termination, or to my return to active treatment.

_____ _____

Participant's Signature Date

_____

Print name

Client Name:_____
CID#: _____

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES
Cobb Mental Health (MH) Court ONLY

Section A: Use or Disclosure of Health Information
By signing this form, I authorize the use and/or disclosure of my individually identifiable health information maintained by: **Cobb/Douglas County Community Services Board (3830 South Cobb Drive Smyrna, GA 30080).**

My health information may be disclosed or sent TO or AMONG the following: **Cobb County Mental Health Court, Cobb County Jail and Cobb Wellstar, any prosecutor designated by the Cobb County District Attorney, Cobb County Circuit Defender's Office, and any member of the Mental Health Court team.**

Section B: Scope and Use of Disclosure
Information that may be used or disclosed based on this authorization includes all psychotherapy notes. "Psychotherapy notes" are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group counseling session.

__Exclude the following information: _____

I understand that my record may include information pertaining to the identity, diagnosis, prognosis, or treatment for alcohol or drug abuse, information pertaining to testing and/or treatment related to HIV or AIDS and any related conditions, and privileged communications between licensed professional staff and me or between them concerning my communications with any of them. Unless otherwise indicated above, by signing this release I authorize the release of alcohol or drug, HIV or AIDS and related conditions, and privileged communications contained in my record.

Section C: Purpose: **Client's participation in the Cobb County Mental Health Court program.**

Section D: Expiration: **Upon completion of the Mental Health Court program or withdrawal from the program.**

Section E: Other Important Information

1. I understand that the Cobb County Mental Health Court Program and its representatives cannot guarantee that the recipient of this information will not redisclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the client or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42CFR, Part 2).
2. I understand that if I refuse to sign this Authorization, I cannot participate in the Mental Health court program.
3. I understand that I may revoke this authorization in writing at any time, except that if I do so, I cannot continue to participate in the Mental Health Court program. Also, my revocation will not have any effect on any action taken in reliance on this authorization before written notice of revocation is received. (See Notice of Privacy Practices)

_____ _____ _____AM/PM
Signature of Client Date Time

Client's Date of Birth: _____ Client's Social Security Number: _____

_____ _____ _____AM/PM
Signature of Parent or Legal Guardian *(if applicable)* Date Time

_____ _____ _____AM/PM
Signature of Witness (Title/Relationship to Client) Date Time

****

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

_____ _____
(Date this consent is revoked by client) (Client Signature)

cc: Client

Client Name: _____
CID#: _____

AUTHORIZATION FOR RELEASE OF INFORMATION- Cobb Mental Health (MH) Court ONLY

Section A: Use or Disclosure of Health Information
By signing this form, I authorize the use and/or disclosure of my individually identifiable health information maintained by: **Cobb/Douglas County Community Services Board (3830 South Cobb Drive Smyrna, GA 30080).**

My health information may be disclosed or sent TO or AMONG the following: **Cobb County Mental Health Court, Cobb County Jail and Cobb Wellstar, any prosecutor designated by the Cobb County District Attorney, Cobb County Circuit Defender's Office, and any member of the Mental Health Court team.**

Section B: Scope and Use of Disclosure
Information that may be used or disclosed based on this authorization includes all health information including: **Attendance, Drug Screen Results, Discharge Summaries, Psychiatric Evaluations, Plans of Care, Physician Orders, Lab Reports, Physical Exams, Nursing Assessments and Progress notes.** ***The release of psychotherapy notes must be authorized separately.

__Other (Specify) _____

__Exclude the following information: _____

I understand that my record may include information pertaining to the identity, diagnosis, prognosis, or treatment for alcohol or drug abuse, information pertaining to testing and/or treatment related to HIV or AIDS and any related conditions, and privileged communications between licensed professional staff and me or between them concerning my communications with any of them. Unless otherwise indicated above, by signing this release I authorize the release of alcohol or drug, HIV or AIDS and related conditions, and privileged communications contained in my record.

Section C: Purpose: **Client's participation in the Cobb County Mental Health Court program.**

Section D: Expiration: **Upon completion of the Mental Health Court program or withdrawal from the program.**

Section E: Other Important Information

4. I understand that the Cobb County Mental Health Court Program and its representatives cannot guarantee that the recipient of this information will not redisclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the client or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42CFR, Part 2).
5. I understand that if I refuse to sign this Authorization, I cannot participate in the Mental Health court program.
6. I understand that I may revoke this authorization in writing at any time, except that if I do so, I cannot continue to participate in the Mental Health Court program. Also, my revocation will not have any effect on any action taken in reliance on this authorization before written notice of revocation is received. (See Notice of Privacy Practices)

_____ _____ _____AM/PM
Signature of Client Date Time

Client's Date of Birth: _____ Client's Social Security Number: _____

_____ _____ _____AM/PM
Signature of Parent or Legal Guardian *(if applicable)* Date Time

_____ _____ _____AM/PM
Signature of Witness (Title/Relationship to Client) Date Time

****

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

_____ _____
(Date this consent is revoked by client) (Client Signature)

cc: Client