MACON COUNTY MENTAL HEALTH COURT REFERRAL

Defendant Name:_____ Referral Date:_____

DOB:_____ Sex:_____ Ethnicity:_____ Veteran: ___Yes ___No

S.S.#_____ D.L. #_____

Address_____

City/State/Zip:_____

Telephone #_____ Cell #_____

Case Number(s):_____

Offense(s):_____

Referral Source:_____
Law Enforcement___ State's Attorney___ Public Defender___ Jail___ Court Services___
Heritage Behavioral H.C.___ Private Attorney___ Family Member___ Self___ Other___

Referral Phone:_____Referral Fax:_____

Address_____

City/State/Zip:_____

Eligible: A defendant may be admitted into the Mental Health Court program only upon the agreement of the prosecutor and the defendant and with the approval of the Court; must be a resident of Macon County; and must be at least 18 years of age.
Not Eligible: Defendants will be excluded from this program if they have been convicted of a crime of violence within the past 10 years excluding incarceration time; or do not demonstrate a willingness to participate in a treatment program.

Date Completed/Forwarded to Section II:_____Initial_____

Forward all referrals to:
Ralf Pansch
Specialty Courts Administrator
Macon County Probation & Courts Services
333 S. Main St.
Decatur, IL 62523
217.424.5814 (phone) * 217.424.1386 (fax)
rpansch@probation.co.macon.il.us

MACON COUNTY MENTAL HEALTH COURT REFERRAL

RELEASE OF INFORMATION

Defendant Name:_____ DOB:_____

Address_____

City/State/Zip:_____

Case Number(s):_____

I authorize the Macon County Mental Health Court to secure the following information:

___Summary of Treatment
___Summary of Psychiatric Treatment
___Psychiatric Evaluation
___Psychological Evaluation/Test Results
___Medical Records
___Other_____

___Individual Treatment Plan
___Progress Notes
___Initiation of and Attendance in Mental Health Services
___Assessments
___Academic Records

To/From/Between:

___Macon County Mental Health Court
___Macon County State's Attorney
___Heritage Behavioral Health Center
___Other_____

___Macon County Probation & Court Services
___Macon County Public Defender
___St. Mary's Hospital

For the purpose of:

___Continuity of care and treatment planning
___Other_____

___Collecting program statistical/outcome data

I may revoke this consent at any time except to the extent that action has been taken in accordance with it. If I do not revoke it, this consent will expire upon my completion of the Macon County Mental Health Court Program.

- ***I understand that this information may be transmitted in written, verbal and/or electronic form.***
- ***I understand that I have the right to inspect and copy the information to be disclosed.***
- ***It has been explained to me that if I refuse to consent to this release of information, the Mental Health Court Team will be unable to exchange information and coordinate my services.***
- ***I have carefully read and considered this document, and hereby state my understanding of an agreement to its provisions. If unable to read, my signature below certifies that this document was read to me.***

_____ _____
Client Signature (age 18 or older) Date

_____ _____
Witness Signature Date

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to this re-disclosure. Under the Federal Regulations (CFR) Title 42, Confidentiality of Alcohol and Drug Abuse Records, July 1975, no such records, or information from such records may be further disclosed without specific authorization for such re-disclosure.

Forward release to:
Ralf Pansch, Specialty Courts Administrator
Macon County Probation & Courts Services
141 S. Main St., Decatur, IL 62523
217.424.1444 ext. 5814 (phone), 217.424.1386 (fax)
rpansch@probation.co.macon.il.us

MEDIA RELEASE

I authorize the Macon County Mental Health Court to release the following information: photographs, videos and/or motion pictures, electronic/video images, sound and video recordings and written correspondence.

This information may be released to: media outlets, including newspapers, cable and broadcast television, Internet usage, brochures, and/or displays.

This release is completely voluntary. You do not have to agree to sign the Media Release to participate in Mental Health Court.

This permission shall continue unless I revoke the permission in writing.

_____ _____

Client Signature (age 18 or older) Date

_____ _____

Witness Signature Date