

# MACON COUNTY MENTAL HEALTH COURT REFERRAL

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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): \_\_\_\_\_

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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:

<input type="checkbox"/> Summary of Treatment	<input type="checkbox"/> Individual Treatment Plan
<input type="checkbox"/> Summary of Psychiatric Treatment	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Initiation of and Attendance in Mental Health Services
<input type="checkbox"/> Psychological Evaluation/Test Results	<input type="checkbox"/> Assessments
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Academic Records
<input type="checkbox"/> Other	

To/From/Between:

<input type="checkbox"/> Macon County Mental Health Court	<input type="checkbox"/> Macon County Probation & Court Services
<input type="checkbox"/> Macon County State's Attorney	<input type="checkbox"/> Macon County Public Defender
<input type="checkbox"/> Heritage Behavioral Health Center	<input type="checkbox"/> St. Mary's Hospital
<input type="checkbox"/> Other	

For the purpose of:

<input type="checkbox"/> Continuity of care and treatment planning	<input type="checkbox"/> Collecting program statistical/outcome data
<input type="checkbox"/> Other	

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](mailto:rpansch@probation.co.macon.il.us)

# MACON COUNTY MENTAL HEALTH COURT REFERRAL

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## 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

