MENTAL HEALTH DIVERSION COURT PROGRAM
Consent to Release Information and
Consent to Obtain Information

Return document to Patient's Attorney	
Attorney Name	
Email	

To determine the appropriate treatment for me while in the Mental Health Diversion Court Program,

I, ______________________________________, authorize the Solano County Superior Court's Mental

Health Diversion Program to exchange (***provide and receive)*** information pertaining to me with staff

from the following entities:

Superior Court of California, County of Solano
Solano County Probation Department
Solano County Public Defender's Office
Solano County Alternate Defender's Office
Solano County District Attorney's Office
Law Offices for my attorney of record
Solano County Behavioral Health
Solano County Substance Abuse Administration
Solano County Forensic Triage Team
Caminar/MIOCR

I authorize the following treatment providers to release my medical and mental health information:
Kaiser Permanente
Health information to be released: Form Completion

Information about me that may be released/obtained from the entities listed above may include, but not limited to, assessments performed on me, my medical history, my treatment plan, my progress in treatment, clinical data and diagnoses, blood/urine test and toxicology results. Participant will not be denied treatment if this consent form is not signed. A copy of this authorization is as valid as the original and the undersigned has the right to receive a copy of this authorization.

I understand that my records are protected by the provisions of 42 United States Code (USC) Section 2990dd-2, and the regulations implementing these laws at 42 Code of Federal Regulations (CFR), Part 2, and the Code of Federal Regulations 45, Parts 160 and 164 (HIPAA), which cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that such action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specify, event, or condition upon which this consent expires)

Date: ______________________
This release is valid only one year from date signed above.

____
Participant (print name)

____
Signature of Participant

____
Participant Medical Record Number