DEFENSE ATTORNEY INSTRUCTIONS

STEP 1: Submit the following documents to the Forensic Outpatient Services Office.

A. Defense Attorney Information Form (attached); This is a fillable Form. Signature fields are not fillable and will need to be signed by the defense counsel.

B. Original completed Authorization to Release/Receive Protected Health Information Forms (A&R Form attached) must be correctly completed, signed by the Defendant for known previous treating entities, and forwarded by the Defense Attorney to previous treating entities.

- **Do not** put client's name on the A & R where the previous treating entity's name should be placed.
- Ensure the client's name, date of birth, and social security number are ***legible*** and placed in the section indicated on the A&R form.
- **Do not** send **blank** releases that only contain your client's signature. A&Rs ***cannot*** be altered by Alabama Department of Mental Health (ADMH) Outpatient Forensics staff after the form is received.
- *A&R forms ***must*** be witnessed. *

Veterans
The included Department of Veterans Affairs Request For and Authorization To Release Health Information (VA Form 10-5345) must be completed and submitted to Veterans Affairs if your client received treatment relevant to the request for forensic mental health evaluations.

Clients Not Capable of Giving Consent
Request an Order for Production of Records from the court. The previous treating entity(ies) must be listed on the Order for Production of Records.

Intellectual Functioning
Submit a student records request to the applicable school district(s). Forward school records to the ADMH Forensic Outpatient Services office once received.

STEP 2: Send ***ORIGINAL*** signed release forms(s) and signed court orders to previous treating entity(ies).
STEP 2 IS THE RESPONSIBILITY OF THE DEFENSE ATTORENY.

STEP 3: Send the Defense Attorney Information Form and a copy of the completed A& R form(s) to the ADMH Forensic Outpatient Services centralized email at fop.dmh@mh.alabama.gov (preferred).
DO NOT SEND TO INDIVIDUAL STAFF EMAIL ADDRESSES.

or

Mail to:
Alabama Department of Mental Health
Mental Health & Substance Use Services Division
Attention: Kimberly T. Bowens, MS, LMHC, NCC
Administrator II-Forensic Outpatient Services Manager & Court Liaison
100 North Union Street, Suite 420
Montgomery, AL 36130-1410
(334) 353-4950

COVER SHEET

DEFENDANT'S NAME _____

DEFENDANT'S CURRENT LOCATION: _____ JAIL _____ ON BOND

RACE: _____ SEX: _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER: _____

DEFENDANT'S TELEPHONE NUMBER: _____

DEFENDANT'S EMAIL ADDRESS (If known): _____

CONFIRMATION OF CASE NUMBERS(S) CHARGES(S) BY COURT FILE:

CASE NO: _____ CHARGE: _____

CASE NO: _____ CHARGE: _____

CASE NO: _____ CHARGE: _____

JUDGE: _____

DEFENSE ATTORNEY: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

DISTRICT ATTORNEY: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

NEXT COURT DATE: _____

Forward Cover Sheet with the following document to fop.dmh@mh.alabama.gov.

or

Mail to:
Alabama Department of Mental Health
Mental Health & Substance Use Services Division
Attention: Kimberly T. Bowens, MS, LMHC, NCC
Administrator II-Forensic Outpatient Services Manager & Court Liaison
100 North Union Street, Suite 420
Montgomery, AL 36130-1410
(334) 353-4950

Alabama Department of Mental Health

Forensic Outpatient Services
RSA Union Building
100 North Union Street, Suite #420
Post Office Box 301410
Montgomery, AL 36130-1410
Telephone: (334) 353-4950
E-Facsimile: (334) 230-5546

DEFENDANT NAME: _____

RACE/SEX: _____ **DOB:** _____

SOCIAL SECURITY NO.: _____

Defense Attorney Information

Side 1

Pending Charge(s)/Case Number(s): _____

_____

_____

Extent of contact with defendant/date of last contact:_____

_____

_____

Observation/Information regarding the need for clinical evaluation, including ***specific*** difficulties in communicating with the defendant: _____

_____

_____

_____

_____

Circumstances surround the alleged offense that led you to believe the defendant's mental state is an issue:

_____

_____

_____

_____

_____

Previous convictions/pertinent background information:_____

_____

_____

_____

Previous psychiatric treatment (**HAVE DEFENDANT SIGN THE AUTHORIZATION TO RELEASE/RECEIVE PROTECTED HEALTH INFORMATION FORM FOR EACH TREATING ENTITY. FORWARD FORM(S) TO THE TREATING ENTITY AND A COPY TO THE ADMH FORENSIC OUTPATIENT SERVICES OFFICE.**):

_____

_____

_____

Defense Attorney Information

Side 2

NEXT OF KIN: Name _____ Relationship: _____

Complete Address: _____

_____

Telephone Number: _____

Email Address: _____

Information received from relatives, friends, etc., relevant to defendant's mental condition: _____

_____

_____

Defendant's current location: _____

☐ **Yes, defense counsel *has* explained to the defendant a request has been made for a forensic evaluation.**

☐ **No, defense counsel *has not* explained to the defendant a request has been made for a forensic evaluation. If no, explain the reason.**

_____

Date: _____

Attorney: _____

Address: _____

_____

Email Address: _____

Telephone Number: _____

Cell Phone Number: _____

Please return this form, copies of Authorization to Release/Receive Protected Health Information form(s), pertinent reports and/or records, and case discovery information you may have to:

ADMH Forensic Outpatient Services centralized email at fop.dmh@mh.alabama.gov (preferred).

DO NOT SEND TO INDIVIDUAL STAFF EMAIL ADDRESSES.

or

Mail to:

Alabama Department of Mental Health
Mental Health & Substance Use Services Division
Attention: Kimberly T. Bowens, MS, LMHC, NCC
Administrator II-Forensic Outpatient Services Manager & Court Liaison
100 North Union Street, Suite 420
Montgomery, AL 36130-1410
(334) 353-4950

Alabama Department of Mental Health
Forensic Outpatient Program
RSA Union Building
100 North Union Street, Suite #420
Post Office Box 301410
Montgomery, Alabama 36130-1410
Phone: 334-242-3732 Fax: 334-230-5546

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

ADMH Record #: _____

AUTHORIZATION TO RELEASE/RECEIVE PROTECTED HEALTH INFORMATION

I authorize ADMH Forensic Outpatient Program to: **Release to** ✓ **Receive from**

_____

Previous Treating Facility: _____

_____

Address: _____

_____

City: _____ State: _____ Zip: _____

copies of my health information for the treatment period _____ (date) to _____ (date).

I specifically authorize the release of the following information: _____

_____.

Purpose for disclosure: _____.

I understand that information contained in the documents to be released may include, but is not limited to, drug and alcohol use, abuse or dependency or related conditions, sexually transmitted disease or sexual orientation, behavioral or mental health conditions, Immunodeficiency Syndrome (AIDS) diagnosis and AIDS related conditions.

I further understand my authorizing the disclosure/obtaining of my health information is voluntary. I understand I need not sign this form in order to receive treatment. I understand I may inspect information to be used or disclosed as provided by law. I understand that when the information is disclosed by the ADMH Forensic Outpatient Program pursuant to this authorization, it has no control over the recipient re-disclosing this information.

I understand I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to the Forensic Outpatient Program at the Alabama Department of Mental Health. I may revoke this authorization except to the extent that action has been taken in reliance on the authorization or this authorization was obtained as a condition of obtaining insurance and law provides the insurer the right to contest a claim under the plan. If this authorization is not expressly revoked, it will automatically expire six (6) months from the date of my signature below.

I acknowledge that I have read and fully understand this authorization as it applies to me. My signature authorizes execution of the terms of this document. A copy or facsimile of this authorization will be considered as valid as the original.

_____ _____ _____
Signature of Patient/Legal Representative Date Time

If signed by a legal representative, a description of the representative's authority to act is as follows:

_____

_____ _____ _____
Witness Date Time

NOTE TO PARTY RECEIVING INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law, which prohibits you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted, by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose (Federal Regulation 42 CFR, Part 2).

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

IN THE CIRCUIT COURT OF _____ COUNTY, ALABAMA

STATE OF ALABAMA	)	
	)	
v.	)	**CASE NO.** _____
	)	
_____,	)	
DEFENDANT.	)	

ORDER FOR PRODUCTION OF RECORDS

I, the undersigned Circuit Judge, do hereby certify that, it is having been alleged to me that certain records of the above-named Defendant (DOB _____, SSN: _____) are in the custody of the agencies noted below, that the records are subject to the confidentiality provisions of 38 United States Code Section 7332 and 42 C.F.R. Sections 2.1 59 2.67-1, and that production of the records is necessary to the completion of the psychiatric evaluation and treatment ordered by this Court,

THEREFORE, after weighing the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship and to the treatment services,

CONSIDER, ORDER, ADJUDGE AND DECREE that good cause exists for production and disclosure of the records, ***at no cost to the defendant, defense counsel and/or the Alabama Department of Mental Health***, that other competent evidence or sources of information regarding the patient's condition are not reasonably available, that there is no successful treatment or rehabilitation of other patients, and that the following limitations on disclosure shall be imposed:

1) Disclosure is limited to the following described parts of the patient's records: Hospitalization/Treatment Summaries, Mental Status Examinations, Physical Examinations, Psychological Testing Reports, Social History Studies, Lab & X-Ray Reports, Other (specify):

_____

_____

_____

_____

_____

2) Disclosure is limited to the following agency whose need for information to execute a court order for outpatient mental evaluation is the basis of this order: Alabama Department of Mental Health, Forensic Outpatient Services;

3) A copy of this Order shall be forwarded by the Clerk to the agencies listed below, which shall release the identified records to the attention of Alabama Department of Mental Health, Forensic Outpatient Program, 100 North Union Street, Montgomery, Alabama 36130-1410, upon the receipt of this Court Order.

ORDERED this _____ day of _____, 20_____.

_____
Circuit Court Judge

Distribute to:

DEFENSE ATTORNEY MUST LIST PREVIOUS TREATING ENTITY(IES) AND/OR FACILITY (IF DEFENDANT IS IN CUSTODY):

_____

_____

_____

_____

Alabama Department of Mental Health
Forensic Outpatient Services
100 North Union Street
Post Office Box 301410
Montgomery, Alabama 36130-1410
Email: fop.dmh@mh.alabama.gov
E-Fax: 1 (334) 230-5546

CIRCUIT CLERK TO DISTRIBUTE