

# **MENTAL HEALTH PACKET**

What you will find in this packet:

- **Information on Mental Health Diversion Process for Misdemeanor and Felony Cases (MH-001-INFO)**
- **Sample Petition for Mental Health Diversion and Proposed Order Filing Under Seal**  
Attachment 1 (MH-002)
- **Penal Code §1001.36 Mental Health Diversion Treatment Plan**  
Attachment 2 (MH-003)
- **Contra Costa County Mental Health Diversion Agreement**  
Attachment 3 (MH-004)
- **Consent and Authorization to Release Private Health Information Form**  
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Attachment 4 (MH-005)
- **Treatment Participation and Progress Report**  
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# **SUPERIOR COURT OF CALIFORNIA COUNTY OF CONTRA COSTA**

## **MENTAL HEALTH DIVERSION PROCESS FOR MISDEMEANOR AND FELONY CASES**

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**Effective December 13, 2023**

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Penal Code § 1001.36 creates a discretionary pre-trial diversion procedure for a defendant charged with a misdemeanor or felony, who suffers from a mental disorder listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the symptoms of which can respond to treatment, if the mental disorder played a significant part in the commission of the charged offense.

**A. To be eligible for diversion, ALL of the following requirements must be met:**

1. The court is satisfied the defendant suffers from a mental disorder identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, schizoaffective disorder, or post-traumatic stress disorder, but excluding antisocial personality disorder, and pedophilia.
2. Defense must make a prima facie case of eligibility.
3. Evidence of the defendant's mental disorder shall be provided by the defense and shall include a diagnosis by a qualified mental health expert. In opining that a defendant suffers from a qualifying disorder, the expert may rely on an examination of the defendant, the defendant's medical records, arrest reports, or any other relevant evidence.
4. The court is satisfied the defendant's mental disorder played a significant role in the commission of the charged offense (a nexus connects the mental disorder and the charged offense(s)).
5. After reviewing any relevant and credible evidence, 1001.36(b)(2).
6. In the opinion of a qualified mental health expert (QMHE), the defendant's symptoms motivating the criminal behavior would respond to mental health treatment.
7. The defendant consents to diversion and waives the right to a speedy trial, unless a defendant has been found to be an appropriate candidate for diversion in lieu of commitment pursuant to §1370(a)(1)(B)(iv) and, as a result of his or her mental incompetence, cannot consent to diversion or give a knowing and intelligent waiver of his or her right to a speedy trial.
8. The defendant agrees to comply with treatment as a condition of diversion.
9. The court is satisfied the defendant will not pose an unreasonable risk of danger to public safety, as defined in section 1170.18, if treated in the community. The Court may consider the opinions of the district attorney, the defense, or a qualified mental health expert, and may consider the defendant's violence and criminal history, the current charged offense, and any other factors which the court deems appropriate.
10. The court is satisfied the recommended inpatient or outpatient program of mental health treatment will meet the specialized mental health treatment needs of the defendant.

**B. Offenses NOT eligible for MHD:**

1. Murder or voluntary manslaughter;
2. An offense which requires registration per section 290, except for a violation of section 314;
3. Rape;
4. Lewd or lascivious act on a child under 14 years of age;
5. Assault with intent to commit rape, sodomy, or oral copulation, in violation of section 220;
6. Commission of rape or sexual penetration in concert with another, in violation of section 264.1;
7. Continuous sexual abuse of a child, in violation of section 288.5;

8. A violation of subdivision (b) or (c) of section 11418.

## MENTAL HEALTH DIVERSION PROCEDURES

### I. IDENTIFYING CASES FOR MENTAL HEALTH DIVERSION (MHD) Mental Health Diversion Department: Wednesday at 8:30 a.m.

The Court will rule on each application based on moving papers, declarations, reports and exhibits submitted by counsel. The prosecution is entitled to respond to each application, also with declarations, reports and exhibits. Only in rare circumstances with a compelling showing will the court take testimony related to an application. The defense bears the burden of showing the applicant will meet the MHD eligibility requirements, and that the applicant and the charged offense are suitable for MHD. This hearing may proceed on offers of proof, reliable hearsay, and argument of both counsel.

#### STEPS and REQUIREMENTS TO APPLY FOR MENTAL HEALTH DIVERSION

1. Defense counsel shall contact the Mental Health Diversion District Attorney regarding availability of dates to set the case for MHD consideration prior to filing the Petition for Mental Health Diversion (MHD).\*
2. Defense counsel shall file two copies of a Petition for Mental Health Diversion with exhibits attached in the Mental Health Diversion Department and serve the District Attorney. (**Attachment 1**) The application should explain how each MHD requirement is satisfied.
3. The Court shall set the case for a MHD Status Hearing at the time the application is filed based on date selected by agreement of counsel.
4. At the first appearance in the MHD Department, the court will inquire whether the defense needs more time to obtain necessary information, e.g. the Qualified Mental Health Expert's (QMHE) diagnosis; a proposed treatment plan (out-patient or in-patient) that will meet the client's needs; the applicant wants MHD; the applicant will fully comply with treatment. Similarly, the court will inquire whether the prosecution needs more time to obtain information, e.g. past psychological evaluations; past participation in treatment that may bear on the applicant's likelihood to comply with treatment; criminal history; incident reports.
5. Defense counsel shall submit a proposed treatment plan (**Attachment 2**) and a mental health diversion agreement (**Attachment 3**) signed by the defendant. The treatment plan will identify the treatment provider and confirm that the treatment provider has screened and accepted the defendant. The plan will also address the requirement that the defendant will have a long-term plan in place for mental health care at the end of diversion. This must be provided to the prosecutor and the court in advance of the hearing. If the court determines the proposed plan is not sufficient for MHD participation, the court will give counsel a reasonable period of time to augment the treatment plan.

\*If counsel believes that the defendant is eligible for services from Contra Costa County Forensic Mental Health—which, at a minimum requires current enrollment in Contra Costa County Medi-Cal—counsel may reach out to the Deputy District Attorney to seek a stipulation. That stipulation would waive the first court date, set a court date, refer the matter for assessment with Forensic Mental Health, and request that the Court file the supporting documentation under seal. This stipulation does not guarantee that the District Attorney will consent to or that that Court will grant Mental Health Diversion.

6. **Confidentiality, Release of Information (ROI), and Confidential Envelopes:** A defendant must sign a Consent and Authorization to Release Private Health Information form (**2 options provided at Attachment 4**) before any of his/her health information can be disclosed to the court and the parties. The judicial officer and court staff must adhere to the privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 (hereinafter “HIPAA”) when receiving medical information and records and when referring to their contents for Penal Code section 1001.36 purposes. The HIPAA requires the judicial officer to be proactive in protecting medical information and records. Additionally, agencies providing information to the judge will likely have their own privacy and records management requirements; and will usually require the defendant to sign an Authorization for Release of Information before they will provide information to the judge. Documents that must be filed with the court shall be placed in a confidential envelope and filed in the court file. No statement or information procured from statements made by the defendant to any Probation Officer, MHD staff, program case manager, service provider, or any member of the MHD team, including the Judge and District Attorney, that is made during the course of referral to or participation in MHD, shall be admissible in any subsequent action or criminal proceeding in this jurisdiction or shared with any individual, agency, or entity outside of the MHD court. Disclosures required under the law (e.g. Tarasoff warnings) are exempted from this provision.
7. If the court accepts Defendant into MHD, Defendant must then waive their speedy trial right, sign the diversion agreement. Diversion for a felony matter will last no more than two (2) years, and for a misdemeanor matter not more than one (1) year.

## II. REVIEW OF TREATMENT PLAN AND CASE MONITORING FOR COMPLIANCE

### A. CONTINUED STATUS HEARING FOR TREATMENT PLAN

1. Defense counsel shall submit a copy of the treatment plan to the Court and the prosecution **prior** to the initial status hearing.
2. The Court reviews the proposed treatment plan and decides as follows:
  - a. If the treatment plan is suitable; the Court shall grant the motion for MHD and stay the criminal proceedings. The defendant shall have up to two years from this date to complete treatment. The defendant shall sign the Mental Health Diversion Agreement (**Attachment 3**). The defendant shall be ordered to return for a progress report hearing in 30 to 90 days.
  - b. The final version of the approved treatment plan must be submitted to the Court and prosecutor. Any changes to treatment plan requirements over the course of the diversion period will require defense counsel to submit a revised treatment plan that includes the current treatment terms and conditions (as modified).
  - c. Regardless of the future status hearing date, defense counsel must submit monthly status reports to the court and the prosecutor. The written reports are essential to determining whether a participant is fully engaging in the mental health diversion treatment program. Please note the reports must be legible and provide adequate detail as to the individual’s participation in treatment (**Attachment 5**).
  - d. The defendant’s identified service provider or collaborative court case manager must create a treatment plan that targets an individual’s mental health treatment needs, substance use/abuse disorder needs (as indicated) and addresses the behavior(s) related to the

underlying the offense. Treatment plans are flexible, individualized, trauma informed, and based on principles of harm reduction and recovery.

- e. If the treatment plan is not suitable; the Court shall order the defendant to get an updated plan and continue the hearing for 2 to 3 weeks. Once the treatment plan is approved, the Court shall make the same orders noted in (a) above. If the Court does not find the updated treatment plan suitable, the Court may deny the Petition and resume criminal proceedings.

## **B. PROGRESS REPORTS AND APPEARANCES**

1. The Court, in its discretion, may order a participant to appear at any scheduled progress report.
2. Defense counsel shall ensure the treatment provider submits a copy of the progress report to the Court and prosecutor **prior** to the hearing. (\*Documents are due no later than the Thursday before the scheduled Monday hearing.)
3. At the hearing, the Court shall review the progress report for compliance:
  - (a) IF the participant is making progress, set another progress report date (30 to 90 days);
  - (b) IF the participant is not making progress, the Court may:
    - give defendant additional time to comply and continue progress hearing to another date;
    - indicate an intention to terminate defendant from the program and continue criminal proceedings. If requested, the Court may consider scheduling a noticed hearing to hear further evidence on why MHD should be terminated and criminal proceedings resumed;
    - recommend defendant apply for an alternative specialty court (i.e., Behavioral Health Court or Veteran’s Court);
    - refer the participant for conservatorship proceedings (pursuant to Welfare and Institution Code section 5350 et seq.);
    - at any time, prosecution, defense or the clinical provider may provide information to the court that may determine the need for a hearing.

## **C. RESTITUTION ORDERS**

Upon request the court shall conduct a hearing to determine whether restitution, as defined in section 1202.4(f), is owed to any victim as a result of the diverted offense and, if owed, order payment during the diversion period. However, a defendant’s inability to pay restitution due to indigence or mental disorder shall not be grounds for denial of diversion or finding the defendant has failed to comply with the terms of MHD. [Section 1001.36(c)(4).]

## **D. SUCCESSFUL COMPLETION OF MHD**

If the defendant successfully performs on MHD, at the end of the period of diversion, the court shall dismiss the criminal charges that were the subject of criminal proceedings at the time of the initial diversion.

A court may conclude the defendant has performed satisfactorily if the defendant has substantially complied with diversion requirements, has avoided significant new violations of law unrelated to the mental health condition, and has a plan in place for long-term mental health care (Section 1001.36(e)). In making its conclusion, the court shall consider input from prosecution, defense, treatment providers and probation (where applicable).

### **III. TERMINATION OF DIVERSION, MODIFICATION OF TREATMENT OR REFERRAL FOR CONSERVATORSHIP**

#### **A. TERMINATION OF DIVERSION**

1. If any of the following circumstances exists, the court shall, after notice to the defendant, defense counsel, and the prosecution, hold an informal hearing to determine whether criminal proceedings should be reinstated, whether treatment should be modified, or whether the defendant should be conserved and referred to the conservatorship investigator to initiate conservatorship proceedings:
  - (a) The defendant is charged with an additional misdemeanor allegedly committed during the pretrial diversion and that reflects the defendant's propensity for violence;
  - (b) The defendant is charged with an additional felony allegedly committed during the pretrial diversion;
  - (c) The defendant is engaged in criminal conduct rendering him or her unsuitable for diversion;
  - (d) The defendant is performing unsatisfactorily in the assigned program, based upon the opinion of a qualified mental health expert (whom the court may deem an appropriate expert);
  - (e) The defendant is gravely disabled as defined by Welfare and Institutions Code section 5008(h)(1)(B).
  
2. The court may do any of the following:
  - (a) Allow diversion to proceed;
  - (b) Modify and/or increase the treatment level;
  - (c) Terminate diversion and reinstate criminal proceedings. In this instance, the Court and counsel shall select the next court date in the underlying court;
  - (d) Refer the defendant to the Public Guardian for purposes of initiating a conservatorship investigation and evaluation (see below).

#### **B. REFERRAL FOR CONSERVATORSHIP**

The Court, defense counsel, or the District Attorney's Office upon receipt of information from a qualified mental health expert that the defendant may be gravely disabled may notice a hearing to refer the defendant to the Public Guardian for purposes of initiating a conservatorship investigation and evaluation.

1 DEFENSE COUNSEL NAME  
STATE BAR NO.  
2 FIRM NAME  
3 ADDRESS  
4 CITY, STATE ZIP  
PHONE

5 Attorneys for Defendant

6 IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA  
7 IN AND FOR THE COUNTY OF CONTRA COSTA

8 THE PEOPLE OF THE STATE OF CALIFORNIA, )  
9 )  
10 Plaintiff/Petitioner, )  
11 v. )  
12 \_\_\_\_\_, )  
13 Defendant/Respondent. )  
14 )  
15 \_\_\_\_\_ )

Case No. \_\_\_\_\_

PETITION FOR MENTAL HEALTH  
DIVERSION PURSUANT TO  
PENAL CODE SECTION 1001.36  
**Date:**  
**Time:**  
**Dept.**

16 Defendant \_\_\_\_\_ applies for Mental Health Diversion pursuant to Penal  
17 Code section 1001.36. Defendant is charged with a qualifying crime, this matter is  
18 timely filed, and Defendant is prima facie eligible for diversion.

19 Defendant suffers from a qualifying mental disorder:

- 20 [ ] Attached is a recent mental health diagnosis; or
- 21 [ ] Defendant will provide a recent mental health diagnosis; or
- 22 [ ] Defendant requests appointment of a qualified mental health expert  
23 pursuant to Evidence Code section 730 to secure the necessary recent diagnosis.

24 Defendant requests that the exhibits containing confidential health information be  
25 filed under seal.

26 Defendant requests this application be set for informal hearing for a prima facie



1 showing that the disorder played a significant role in the commission of the offense(s),  
2 and that a qualified mental health expert will opine that defendant’s symptoms underlying  
3 the criminal behavior would respond to treatment.

4 Defendant consents to mental health diversion; defendant is prepared to waive  
5 [his]/[her]right to a speedy trial; defendant will comply with an appropriate treatment  
6 program; and defendant does not pose an unreasonable risk of danger to public safety  
7 within the meaning of Penal Code section 1170.18.

8  
9 Date:

Respectfully Submitted,

10  
11  
12 \_\_\_\_\_  
13 [ATTORNEY NAME]

1 DEFENSE COUNSEL NAME  
STATE BAR NO.  
2 FIRM NAME  
3 ADDRESS  
4 CITY, STATE ZIP  
PHONE

5 Attorneys for Defendant

6 IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA  
7 IN AND FOR THE COUNTY OF CONTRA COSTA

8 THE PEOPLE OF THE STATE OF CALIFORNIA, )  
9 )  
10 Plaintiff/Petitioner, )  
11 v. )  
12 \_\_\_\_\_, )  
13 Defendant/Respondent. )  
14 )

Case No. \_\_\_\_\_

[PROPOSED] ORDER REGARDING  
FILING UNDER SEAL

15 Defense Counsel has filed a Petition for Diversion pursuant to Penal Code section  
16 1001.36.

17 The defense exhibits are ordered filed under seal.

18 It is so ordered.

19 Dated:

20  
21  
22 \_\_\_\_\_  
The Honorable Julia Campins  
23 Judge of Superior Court  
24  
25  
26

**PENAL CODE §1001.36 MENTAL HEALTH DIVERSION TREATMENT PLAN**

**Participant's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Docket No.** \_\_\_\_\_

**Next Court Date:** \_\_\_\_\_

**Treatment Provider:** The above-named person is applying for Contra Costa County Court's Mental Health Diversion. The Mental Health Diversion Court requires that an individual provide a Mental Health Diversion Treatment Plan. Please complete the below information and either provide this form back to the participant or you may provide it directly to the participant's attorney of record indicated below, by fax or electronic mail. Please submit before the next court date noted above.

**Attorney of Record:** \_\_\_\_\_ **Telephone No.:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_ **Fax No.:** \_\_\_\_\_

**Provider's Name:** \_\_\_\_\_ **Provider's Agency:** \_\_\_\_\_  
**Provider's Contact Information (phone, email):** \_\_\_\_\_

**Patient is suffering from a mental disorder diagnosed as:** \_\_\_\_\_

**Symptoms include:** \_\_\_\_\_

**Based on the above-diagnosis, Patient's symptoms would respond to the following mental health treatment plan:**

Attend psychiatric appointments  
 Name of doctor (if different from undersigned) \_\_\_\_\_  
 Frequency of appointments \_\_\_\_\_ Length of appointment \_\_\_\_\_  
 Next appointment \_\_\_\_\_

Take medication(s) as prescribed  
 Name of provider prescribing medications for mental disorder \_\_\_\_\_  
 Frequency of medication assessments: \_\_\_\_\_  
 Medications currently prescribed include: \_\_\_\_\_  
 Additional medications to be prescribed: \_\_\_\_\_

Attend individual meetings/therapy with provider  
 Name of provider (if different from undersigned) \_\_\_\_\_  
 Frequency of sessions \_\_\_\_\_ Length of appointment \_\_\_\_\_  
 Description/Purpose of meetings \_\_\_\_\_

Attend group meetings/therapy with provider  
 Name of provider (if different from undersigned) \_\_\_\_\_  
 Frequency of sessions \_\_\_\_\_ Length of appointment \_\_\_\_\_  
 Description/Purpose of meetings \_\_\_\_\_

Participant's Name: \_\_\_\_\_

- Attend Anger Management and/or 52 week Domestic Violence Program (circle one)
  - Name of provider (if different from undersigned) \_\_\_\_\_
  - Frequency of sessions \_\_\_\_\_ Length of appointment \_\_\_\_\_

- Submit to random drug and/or alcohol testing
  - \*Results of drug and/or alcohol testing to be provided to participant's attorney in advance of hearing**
  - Frequency of testing \_\_\_\_\_
  - Drug testing results will screen out specific drugs (i.e., component of prescribed medication(s)): \_\_\_\_\_

- OTHER TREATMENT RECOMMENDATIONS
  - Name of provider (if different from undersigned) \_\_\_\_\_
  - Frequency of sessions \_\_\_\_\_ Length of appointment \_\_\_\_\_
  - Description/Purpose of treatment \_\_\_\_\_

I believe patient can be treated in the community if patient agrees to comply with this plan.

Signature of Agency Representative	Print Name	Date
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I agree to comply with this treatment plan.

Signature of Patient	Print Name	Date
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**CONTRA COSTA COUNTY MENTAL HEALTH DIVERSION AGREEMENT**

**Defendant** \_\_\_\_\_

**CASE NUMBER (S)** \_\_\_\_\_

I, \_\_\_\_\_, hereby request Mental Health Diversion. I understand that if I am granted diversion by the Judge, I must follow the rules and conditions of the program or my Diversion may be terminated. I have fully discussed the charges with my attorney, possible defenses and options, including Mental Health Diversion.

1. I understand that if granted Diversion, the program may last for up to 24 months based on my individual performance. During that time, I agree to abide by all the rules and conditions of my treatment plan and any other conditions set by the Judge, including the payment of restitution if ordered.

2. I agree to provide my attorney and the Court with my current address, as well as an accurate phone number (if I have one) where I may be reached directly, and that I will immediately notify my attorney and the Court of any changes in my address and/or any change in the phone number where I can be reached directly. If I do not have a current phone number, I agree to provide contact information which enables my attorney to reach me.

3. I will attend all appointments and court hearings on time and as scheduled.

4. I will fully participate in the treatment plan as set out by the Judge and/or my treatment provider. I specifically agree to report regularly to any treatment provider stated in the plan and to participate in all activities at the times and places stated in my treatment plan including, but not limited to, taking medications, submitting to drug and alcohol testing, attending, mental health and substance abuse treatment, therapy, support groups and such other treatment as may be required until completion of the program.

5. I will take all medications that are prescribed and continue to take them as directed at all times.

6. I fully understand that my treatment plan will change over the period of my participation in diversion, and that requirements and new conditions may be added. I agree to fully comply with any changes to my treatment plan and/or conditions set by the Judge.

7. In the event that I do not adhere to the above requirements or I am unsuccessful in the program as determined by the Court, the criminal proceedings in my case will be reinstated and my case will be returned for trial.

**DATE:** \_\_\_\_\_

\_\_\_\_\_  
**Defendant's Signature**

**CONTRA COSTA HEALTH SERVICES  
CONTRA COSTA REGIONAL MEDICAL CENTER AND HEALTH CENTERS  
AUTHORIZATION FOR CONTRA COSTA  
HEALTH SERVICES (CCHS) TO USE  
OR DISCLOSE PROTECTED HEALTH INFORMATION**

MRN:

<b>PATIENT INFORMATION (PLEASE PRINT)</b>			
FIRST NAME	MIDDLE INITIAL	LAST NAME	
OTHER NAME AT TIME OF TREATMENT (IF DIFFERENT THAN ABOVE)			
DATE OF BIRTH (MM/DD/YEAR)			
STREET ADDRESS	CITY	STATE	ZIP
<b>PHONE NUMBERS</b>			
HOME	MOBILE	WORK	
PLEASE CHECK PREFERRED PHONE FOR CONTACT/MESSAGES: <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> WORK			

I am the  Patient  Parent/Guardian  Conservator  Other \_\_\_\_\_  
and hereby authorize Contra Costa Health Services (CCHS) to use or disclose health information of the above-named individual to:

<b>SEND/DELIVER RECORDS TO</b>	<input type="checkbox"/> SAME AS ABOVE	<input type="checkbox"/> OTHER NOTED BELOW
NAME OF PERSON, ORGANIZATION, AGENCY		
STREET ADDRESS	CITY	STATE ZIP
PHONE NUMBER	FAX NUMBER	
PURPOSE:	<input type="checkbox"/> PERSONAL USE (AB610)	<input type="checkbox"/> FORM <input type="checkbox"/> OUTSIDE HEALTH CARE PROVIDER
	X OTHER: 3rd Party Authorization	

<b>WHAT RECORDS DO YOU WANT?</b>
DATE(S) OF TREATMENT: _____ / _____ / _____ THROUGH _____ / _____ / _____
INPATIENT:
<input type="checkbox"/> STANDARD (INCLUDES DOCTOR ASSESSMENTS AND REPORTS, PROGRESS NOTES, TEST RESULTS, MEDICATION)
<input type="checkbox"/> ENTIRE (INCLUDES STANDARD PLUS FLOW SHEETS, NURSING NOTES, ETC.)
<input type="checkbox"/> ADDITIONAL (PLEASE DESCRIBE) _____
OUTPATIENT:
<input type="checkbox"/> CLINIC VISIT NOTE(S) <input type="checkbox"/> TEST RESULT(S): TYPE: _____
<input type="checkbox"/> ED OR PES VISIT(S) <input type="checkbox"/> SURGERY/PROCEDURE REPORT: _____
<input type="checkbox"/> LETTER REPRINT: DATE(S): _____
<input type="checkbox"/> LISTS OF VISITS X OTHER: Please allow verbal and written disclosure of PHI

**CONTRA COSTA HEALTH SERVICES  
 CONTRA COSTA REGIONAL MEDICAL CENTER AND HEALTH CENTERS  
 AUTHORIZATION FOR CONTRA COSTA  
 HEALTH SERVICES (CCHS) TO USE  
 OR DISCLOSE PROTECTED HEALTH INFORMATION**

DOB:  
 MRN:

<b>HOW WOULD YOU LIKE THE RECORDS PREPARED?</b> <input type="checkbox"/> Release to MyccLink	<input type="checkbox"/> PAPER <input type="checkbox"/> DIGITAL (CD/DVD)
<b>HOW WOULD YOU LIKE THE RECORDS DELIVERED WHEN THEY ARE FOR YOURSELF?</b> <input type="checkbox"/> DELIVERY BY US MAIL <input type="checkbox"/> I WILL PICK THEM UP <input type="checkbox"/> WILL PAY FOR CERTIFIED US MAIL <input type="checkbox"/> RELEASE TO MyccLink	

**INFORMATION TO BE RELEASED:** This is a **full disclosure** authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. *Your initial below indicates you understand and agree.*

\_\_\_\_\_ **NO Exclusions**  
 INITIAL

*Please initial below to indicate any records you do not want released in this request:*

- \_\_\_\_\_ Exclude HIV test results  
 INITIAL
- \_\_\_\_\_ Exclude Substance Abuse treatment information  
 INITIAL
- \_\_\_\_\_ Exclude Behavioral Health treatment information  
 INITIAL
- \_\_\_\_\_ Exclude other (Specify): \_\_\_\_\_  
 INITIAL

**RE-DISCLOSURE:** If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. This authorization is effective immediately and will remain in effect for one (1) year or until \_\_\_\_\_ (date or event). I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that CCHS has acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. If I am being asked by CCHS to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility of benefits will be conditioned on my providing or refusing to provide this Authorization.

<b>SIGNATURES</b>	
DATE	PATIENT SIGNATURE
AUTHORIZED SIGNATURE (IF OTHER THAN PATIENT)	RELATIONSHIP
SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED	
EMPLOYEE NAME	DATE

**CONTRA COSTA HEALTH SERVICES**

- CONTRA COSTA ALCOHOL & OTHER DRUG SERVICES
  - CONTRA COSTA PUBLIC HEALTH
  - CONTRA COSTA MENTAL HEALTH
- CONTRA COSTA REGIONAL MEDICAL CENTER
  - CONTRA COSTA HEALTH CENTERS

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

PATIENT NAME	DATE OF BIRTH	RECORD #
AKA (OTHER NAME)		
STREET ADDRESS		PHONE #

I am the  **PATIENT**  **GUARDIAN**  **CONSERVATOR**  **DESIGNEE** and hereby authorize Contra Costa Health Services to use or disclose health information of the above named individual **TO:**

SEND TO (NAME OF PERSON, ORGANIZATION, AGENCY) Mental Health Diversion Court, Judge Julia Campins Department 10	
ADDRESS 1010 Ward Street, Martinez, CA 94553 Dept10@contracosta.courts.ca.gov	PHONE # 925.608-1110
<b>PURPOSE FOR DISCLOSURE</b> <input type="checkbox"/> At the request of the individual. <b>Mental Health Diversion, pursuant to Penal Code section 1001.36</b>	
DATES & TYPE OF INFORMATION TO BE DISCLOSED Substance abuse and mental health treatment attendance and progress	

**RE-DISCLOSURE:** If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law and a federal law governing drug abuse patient records prohibit recipients of your health information from re-disclosing such information, except with your written authorization or as specifically required or permitted by law.

**INFORMATION TO BE RELEASED:** This is a **full disclosure** authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. These records will be disclosed unless you specify information you wish excluded. Please initial below information you do not want released:

_____ NO Exclusions.	Exclude: _____ Exclude HIV test results	
INITIAL	INITIAL	
_____	Exclude Substance Abuse treatment information	
INITIAL	INITIAL	
_____	Exclude Mental Health treatment information	
INITIAL	INITIAL	
_____	Exclude other information _____	
INITIAL	INITIAL	

This Authorization is effective immediately and will remain in effect for one year or until (date or event) \_\_\_\_\_, whichever comes first. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that Contra Costa Health Services has acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. If I am being asked by Contra Costa Health Services to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

**This information will be kept confidential as required by Penal Code section 1001.36(h)-(i).**

<b>Date</b>	<b>Patient Signature</b>	SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED	
Signature of Parent, Guardian, etc.	Relationship	EMPLOYEE NAME	DATE



**TREATMENT PARTICIPATION AND PROGRESS REPORT**

Participant's Name: \_\_\_\_\_  
Docket No. \_\_\_\_\_

Progress Period: \_\_\_\_\_  
\_\_\_\_\_  
*(rpt. period every 30 days)*

Next Court Date: \_\_\_\_\_

**Treatment Provider:** Contra Costa County Superior Court's Mental Health Diversion Program requires monthly reports of participant's progress in treatment. A separate form **must** be completed for every 30 days of treatment. Please reference the treatment plan when you complete the **entire** form and provide to the participant or his/her attorney of record. Please submit at the end of each month. The last month's report in the progress period must be submitted at least two days before the next court date (noted above).

**Attorney of Record:**

**Email:**

**Phone:**

**Fax:**

**District Attorney:** Kristina McCosker  
**Phone:** (925) 957-8758

**Email:** DA-MHU@contracostada.org  
**Fax:** (925) 646-4445

**Provider's Name:** \_\_\_\_\_ **Provider's Agency:** \_\_\_\_\_  
**Provider's Contact Information (phone, email):** \_\_\_\_\_

**During the progress period indicated above, the participant (was):**

- Medication compliant  Noncompliant  No meds or provider unaware if meds ordered (circle one)
- Attended all treatment sessions  Missed sessions (dates and explanation) \_\_\_\_\_  
\_\_\_\_\_
- Engaged and making progress (**explanation required – use space below**)
- Lacked engagement or progress (includes partial or no compliance) (**explanation required – use space below**)

**Treatment Dates (include length & type of appt.):** \_\_\_\_\_

**Provider Recommendation (if any) to modify plan:** \_\_\_\_\_

**During the progress period (above) participant submitted to random substance testing:**

Dates/Frequency of testing (note any missed tests): \_\_\_\_\_

Dates/Results of tests: \_\_\_\_\_

Substances identified in positive drug testing results: \_\_\_\_\_

*Comments (MANDATORY to complete - specifics re: compliance /progress/complications & recs: (if more space needed, attach additional sheets) Must be legible.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Treatment Provider

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date