# MIAMI-DADE VETERANS TREATMENT COURT REFERRAL FORM

Referral date: _____

Referred by: _____ Public Defender _____ Private Counsel _____ State Attorney _____ Judiciary
_____ Other (*please specify:* _____)

Defense Attorney Name: _____

Phone number: _____

Email: _____

State Attorney Name: _____

**CLIENT INFORMATION**

Name: _____

Street address *(indicate if defendant is homeless)*: _____

City: _____ State: _____ Zip Code: _____

Primary phone: _____ Secondary phone: _____

Race: _____ Ethnicity: _____

Gender: _____ DOB: _____ SSN: _____

Dates of military service *(optional)*: _____

Is the defendant currently linked with the VA? _____ YES _____ NO

Identify which VA if outside of Miami-Dade: _____

Is the defendant currently in jail? _____ YES _____ NO

**CASE INFORMATION**

Case No.: _____ Charge(s): _____

Notes: _____

**After you have filled out this referral form <u>in its entirety</u>, with all completed and signed releases of information included, please email the documents to VTC@jud11.flcourts.org (number 305-548-5296).**

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# REQUEST PERTAINING TO MILITARY RECORDS

**Requests can be submitted online using eVetRecs at http://www.archives.gov/veterans/military-service-records/**
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

## SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

| 1. NAME USED DURING SERVICE (last, first, full middle) | 2. SOCIAL SECURITY # | 3. DATE OF BIRTH | 4. PLACE OF BIRTH |
|---|---|---|---|
| | | | |

**5. SERVICE, PAST AND PRESENT** *(For an effective records search, it is important that ALL service be shown below.)*

| | BRANCH OF SERVICE | DATE ENTERED | DATE RELEASED | OFFICER | ENLISTED | SERVICE NUMBER (If unknown, write "unknown") |
|---|---|---|---|---|---|---|
| a. ACTIVE | | | | ☐ | ☐ | |
| b. RESERVE | | | | ☐ | ☐ | |
| c. NATIONAL GUARD | | | | ☐ | ☐ | |

6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN: 1. _____ 2. _____ 3. _____ 4. _____

7. IS THIS PERSON DECEASED? ☐ NO ☐ YES - *MUST provide Date of Death if veteran is deceased:* _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

## SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

**1. CHECK THE ITEM(S) YOU ARE REQUESTING:**

☒ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation): _____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits.** If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
***An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box:*** ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.

☐ I request inpatient/hospitalization records from _____(facility), last treated in _____(year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

**2. PURPOSE:** (Providing information about the purpose of the request is **voluntary**; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

## SECTION III - RETURN ADDRESS AND SIGNATURE

**1. REQUESTER NAME:** _____

**2. RELATIONSHIP TO VETERAN:** _____

**3.** ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.
☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)
☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)
☐ OTHER (Specify): _____

**4. SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 4 on accompanying instructions.)

Miami-Dade Veterans Treatment Court
Name

1351 NW 12th St., Room 421
Street Address — Apt. #

Miami — FL — 33125
City — State — ZIP Code

305-548-5296 — 305-548-5610
Daytime Phone — Fax Number

VTC@JUD11.FLCOURTS.ORG
Email Address

**5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information.** *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

SIGN HERE

_____ _____
**Signature Required** – Do not print — **Date**

* This form is available at http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf on the National Archives and Records Administration (NARA) web site. *

## Eleventh Judicial Circuit of Florida
Miami-Dade Veterans Treatment Court

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF CONFIDENTIAL ALCOHOL/DRUG ABUSE AND/OR MENTAL HEALTH CLIENT INFORMATION

I, _____, Case # _____,
(Print Client Name)

do hereby authorize the Miami-Dade Veterans Treatment Court ("VTC") and staff thereof to receive and exchange information with

_____
(Print Name and Address of Program/Facility/Organization)

I willingly and voluntarily authorize the disclosure of information regarding my previous treatment episodes, current and previous substance abuse and mental health history, and current need for treatment, as well as my progress, attendance, and degree of participation in any treatment or components thereof as mandated by the Court ("Information"). The Information may be disclosed to the VTC judge, coordinator, intake specialist, case managers, health staff, employees, and partners of the VTC (collectively "Recipients") as necessary to monitor my treatment as mandated by the Court ("Court Mandate"). I understand that Information pertaining to my attendance and progress in treatment is protected by Federal Regulation 42 C.F.R., Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., Parts 160 & 164. The Information cannot be disclosed without my written consent unless otherwise provided for in the referenced regulations. Should I be mandated to attend treatment or services, I hereby authorize the above-named agency to release all necessary Information to the Recipients for ongoing monitoring of my status. I further authorize the re-disclosure of the information to my attorney, the State Attorney's office, and the Florida Department of Corrections (collectively "Entities"), if applicable.

The extent of the Information to be released and disclosed is my diagnosis, attendance, scope of treatment, treatment progress and quality of participation, dates and results of my urinalysis testing, mental health issues, medical issues, medications, and termination or completion of my treatment.

The purpose and requirement to disclose the above Information are to comply with the conditions of my Court Mandate and to inform the aforementioned Recipients and Entities of my ongoing participation in any mandated treatment so the Court can make informed judicial decisions regarding such participation. My consent for release of such Information is limited to these purposes.

I understand this consent will remain in effect throughout the duration of my participation in the VTC but can be revoked by me, at any time, in writing. I understand, if I refuse to consent to disclosure or attempt to revoke my consent prior to the expiration of this consent, such action is grounds for immediate termination from the VTC.

I understand the Recipients (and Entities, if applicable) who receive this Information may re-disclose it only in connection with their official duties and with respect to the terms of my Court mandated treatment, as deemed by the Court to be for my well-being and in my best interest.

_____ _____ SIGN HERE
Client Date

_____ _____
Witness Date

Pick up: _____
Mail out: _____

Medical Record # _____

# JACKSON HEALTH SYSTEM
## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: _____ TREATMENT DATE(S): _____

PHONE NUMBER: _____

1. Please note that:

- The Public Health Trust is required by federal and state law to protect your health information.
- The person or organization that receives your health information may not be required by federal law to protect it and may share your information with others without your permission. The person or organization that receives your health information may be required under state law to use your information only for the purpose you stated and may not share your information without your written permission. In particular, the receiving person or organization may not be allowed to share any information about HIV test results, substance abuse, psychiatric/psychotherapy or sexual assault without your permission.
- The Trust cannot condition your treatment, payment, enrollment or eligibility for benefits on whether or not you sign this Authorization.
- You do not have to sign this Authorization form, but if you do not, we will not provide your health information to the person or organization you have requested.
- You may change your mind and revoke (take back) this Authorization at any time. If the Trust has not yet released your health information and you change your mind, it will not release your information. However, if the Trust relied on this Authorization before you changed your mind and released your health information, the person we gave it to may still disclose the health information they have already received. The Trust relied on this Authorization if the Trust had forwarded your health information to the person or organization that you requested.
- To revoke this Authorization you must write to the Privacy Officer at Jackson Health System, Jackson Medical Towers, 1500 N.W. 12th Avenue, Suite 102, Miami, Florida 33136.
- Your permission to release your health information will automatically expire twelve (12) months from the date that you signed this form, unless you revoke your permission earlier or you choose a different date: _____ (list a specific date or event - e.g., at the end of the research study, six months from now, etc.).

2. I _____(patient/authorized representative) give permission to the Public Health Trust of Miami-Dade County/Jackson Health System to release health information that identifies _____ patient (Select one of the following):

a. X Complete Medical Record (covering the period(s) of: _____)
(Please note that by selecting this option this will not provide you with your billing records. In order to request your billing records, please select option 2.c. HIV test results may be released with the Complete Medical Record if you have signed a prior written authorization to release HIV test results.): **OR**

b. X Complete Psychiatric/Psychotherapy Record (covering the period(s) of: _____)
(You cannot combine this authorization to release psychiatric/psychotherapy records with any other authorization for release of records. Please complete a second authorization form in order to release any other health records.): **OR**

c. _____ Billing Records (covering the period(s) of: _____)

d. _____ Release shall be limited to the following specific types of information (covering the period(s) of: _____):

_____ Discharge Summary
_____ Emergency Department Record
_____ Progress Notes
_____ Operative Reports
_____ Pathology Reports
_____ EKG Reports
_____ History and Physical Examination
_____ Consultation Reports
_____ Laboratory Tests
_____ X-Rays or other images
_____ Surgical / Autopsy slides
_____ Description of medical condition by name, diagnosis, treatment, etc.
_____ Photographs, videotapes, audiotapes, other recordings
_____ Health Insurance Information
_____ Outpatient Records
_____ Clinical Lab Reports
_____ Other (specify): _____ ; **OR**

e. _____ Other: _____

3. I, _____ give specific consent to release my medical records that relate to the following areas (please sign your name next to all that apply):
Patient/Authorized Representative

_____ HIV Test Results _____ Substance Abuse _____ Sexual Assault

4. The purpose for which my health information is being released is: (please initial)

__X__ Continuing Care __X__ Legal _____ Insurance _____ Personal _____ Other: _____

5. I give permission for the health information listed above to be released to the following individual(s), organization(s) or entity(ies):

Name: Miami-Dade Veterans Treatment Court Phone: 305-548-5296

Address: 1351 NW 12th St. Rm 421 Fax: 305-548-5610 ; OR

Miami, FL 33125

Name: _____ Phone: _____

Address: _____ Fax: _____ ; OR

Name: _____ Phone: _____

Address: _____ Fax: _____ ; OR

Name: _____ Phone: _____

Address: _____ Fax: _____ ; OR

Name: _____ Phone: _____

Address: _____ Fax: _____ ; OR

SIGN HERE

_____ _____
Patient Signature Date

_____
Parent/Authorized Representative – sign and print

_____
Indicate Relationship to Patient

PATIENT IMPRINT

<<Produce in duplicate with instruction to give one copy to patient or authorized representative.>>

Jackson HEALTH SYSTEM | PUBLIC HEALTH TRUST

MIAMI, FLORIDA 33136-1096

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS**

CO0010

Department of Veterans Affairs

# REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

**PRIVACY ACT INFORMATION:** The execution of this form does not authorize the release of information other than that specifically described below. 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 the information including the last four of your Social Security Number (SSN) and Date of Birth (used 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 treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*
Veterans Health Administration
Miami VA Healthcare System
1201 NW 16th Street, Miami, FL 33125

| LAST NAME- FIRST NAME- MIDDLE INITIAL | LAST 4 SSN | DATE OF BIRTH |
|---|---|---|
| | | |

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Eleventh Judicial Circuit, Veterans Treatment Court, VTC Team Members (Judge, Coordinator, Intake Specialist, Case Managers, Veteran Justice Outreach (VJO) Coordinator and Specialist, State Attorney, Defense Attorney), Court Administration, Law Enforcement Officers, Jail/Correctional Staff, and the Miami Vet Center Program.

## VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- [X] DRUG ABUSE
- [ ] SICKLE CELL ANEMIA
- [X] ALCOHOLISM OR ALCOHOL ABUSE
- [ ] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

## DESCRIPTION OF INFORMATION REQUESTED

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

- [ ] HEALTH SUMMARY *(Prior 2 Years)*
- [ ] INPATIENT DISCHARGE SUMMARY *(Dates)*: _____
- [ ] PROGRESS NOTES:
  - [ ] SPECIFIC CLINICS *(Name & Date Range)*: _____
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*: _____
  - [ ] DATE RANGE: _____
- [ ] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____
- [X] LAB RESULTS:
  - [ ] SPECIFIC TESTS *(Name & Date)*: _____
  - [X] DATE RANGE: All drug utox screens past and future as deemed relevant by the Court
- [ ] RADIOLOGY REPORTS *(Name & Date)*: _____
- [X] LIST OF ACTIVE MEDICATIONS
- [X] OTHER *(Describe)*: VHA eligibility/discharge status, medical & mental health diagnoses, treatment outcomes related to psychiatric and substance abuse-related issues

## PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [X] TREATMENT
- [ ] BENEFITS
- [ ] LEGAL
- [X] OTHER *(Specify below)*

Screening, assessment, continuity of care

| LAST NAME- FIRST NAME- MIDDLE INITIAL | LAST 4 SSN | DATE OF BIRTH |
|---|---|---|
| | | |

## 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.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): 30 days after the resolution of court/legal issues

| PATIENT SIGNATURE *(Sign in ink)* | DATE *(mm/dd/yyyy)* |
|---|---|
| | |

SIGN HERE

| 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

VJO will provide a summary of progress via written, verbal, telephonic, and secured email that is required by court for monitoring of patient progress in treatment and compliance with legal conditions of Veterans Treatment Court participation, inclusive of all relevant medical record information both past and future. Information will include but not be limited to: diagnosis (medical, mental health, and substance/ alcohol), relevant labs, medical diagnosis, progress in treatment programming, developmental, social, financial, and military data as relevant to court/legal circumstances to the designated court team and any additional guest as permitted by authorization. Information will be shared at regular intervals as needed by the Court Team to adequately assess progress of Veteran and compliance with court program and probation guidelines. The authorization will expire upon Veteran's discharge or successful completion of court program and probation period which may last longer than the court program. Medical record information is subject to review in open court docket.

| DATE RELEASED | RELEASED BY: |
|---|---|
| | |