ORANGE COUNTY PROBLEM SOLVING COURT REFERRAL FORM

Adult Drug Court: Suite 325, **P:** (407) 836-0419, **F:** (407) 836-0528 **Email:** drugctreferral@ocnjcc.org
Veterans Treatment Court: Suite 510 **P:** (407) 836-0651 **Email:** veteranscourt@ocnjcc.org
Mental Health Court: Suite 510 **P:** (407) 836-0578 **Email:** ctdclv1@ocnjcc.org

DATE: _____ DIV. _____ Program: ADC____ VTC ____ MHC____

REFERRAL TYPE: (Track I) **Diversion** ____ (Track II) **Post Plea** ____ (Track III) **VOP** ____ *Transfer* **IN / OUT**

REFERRED BY: Public Defender ____ Private Counsel ____ Judiciary ____ State Attorney ____ Other ____

Defense Attorney Name: _____ Phone: (_____) _____

Assistant State Attorney Name: _____

CLIENT INFORMATION:

Name: _____, _____, _____
Last First Middle Initial

A/K/A: _____

Street Address **(please indicate if the defendant is homeless):** _____

_____

City: _____ State: _____ Zip Code: _____

Race: B/W/Other: _____ Gender: Male / Female DOB: _____/_____/_____

Primary Phone #: (_____) _____ Secondary Phone #: (_____) _____

SSN: _____ - _____ - _____

Has the defendant ever served in the United States Armed Forces? Yes / No

Is the defendant currently in jail? Yes / No

CASE INFORMATION:

Case No.: _____

Charge(s): _____

Notes: _____

DO NOT WRITE BELOW THIS SECTION (PROBLEM SOLVING COURT OFFICIAL USE ONLY)

CRIMINAL HISTORY CHECK: VERIFIED BY: _____ NOTES: _____

STATE ATTRORNEY'S OFFICE REVIEW:
SAO Reviewed for: DIVERSION _____ POST PLEA _____ VIOLATION OF PROBATION _____
SAO review: APPROVED / DENIED or INCOMPLETE Sentencing Score: _____
SAO Comments: _____

_____

PROBLEM SOLVING COURT PROGRAM OFFICE FINAL REVIEW:
PSCPO Review: APPROVED _____ DENIED/ REASON: _____

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. 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. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

Orlando VA Medical Center
13800 Veterans Way
Orlando, FL 32827

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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

Ninth Judicial Court, Veterans Treatment Court, Veterans Treatment Court Team Members (including VTC Judge, VTC case manager, State Attorney, Public Defender, probation officers, Florida Safety Council, Veteran Service Officers)
425 N. Orange Ave, Orlando, FL 32801

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):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

VA Eligibility, medical and mental health diagnoses, treatment outcomes related to psychiatric and substance abuse-related issues, including prescribed medications and progress notes

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Provide The Court with a current status of treatment, which will require records created after the signature of this authorization, as well as post-release/re-entry planning and jail diversion

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

30 days after resolution of court/legal issues

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. 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. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
Orlando VA Medical Center 13800 Veterans Way Orlando, FL 32827	SOCIAL SECURITY NUMBER

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

Guests of Orange County Veterans Treatment Court (OCVTC) not directly involved with court-directed treatment

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):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

All medical records and health information, past and future, related to court-directed treatment

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

To provide OCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

Upon resolution of court-related/legal issues

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	**TYPE AND EXTENT OF MATERIAL RELEASED**	
	DATE RELEASED	RELEASED BY

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2018

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by 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. STATE NATIONAL GUARD	-			☐	☐	

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

7. 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: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 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.

An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)*** *the FACILITY NAME and DATE (month and year) for EACH admission* ***MUST*** *be provided:* _____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly 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. ☑ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*

\-

(Relationship to deceased veteran)

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

ORANGE COUNTY VETERANS COURT OFFICE

Name

425 N. ORANGE AVE

Street Apt.

ORLANDO FL 32801

City State Zip Code

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

☐ 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 type of Other)

4. 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 III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction 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 if for archival records.)*

Signature Required - Do not print **Date**

(407) 836-0651 (407) 835-5074

Daytime phone Fax Number

veteranscourt@ocnjcc.org

Email address