DEFENSE ATTORNEY INSTRUCTIONS

STEP 1: Submit the following documents to the Forensic Outpatient Program

1. Defense Attorney Information Form (attached): this is a fillable form. Signature fields are not fillable and would need to be signed by the entity requested.

2. ***Copies*** of completed Authorization to Release/Receive Protected Health Information Forms (Release Forms attached) signed by Defendant for any previous treating facilities. These forms should be witnessed. We do not need a release to speak with the client as the court order allows us this privilege. ***Please do not put client's name on the Release of Information where the previous treating facility's name should go. Please do not send back blank releases that only have the client's signature.***

   NOTE: If Defendant is not considered capable of giving consent, please do an order for Production of Records signed by the Judge and submit in the place of a release form. (see attached)

   NOTE: If limited intellectual functioning is an issue, complete release form for school records.

STEP 2: Send Defense Attorney Information form and **copy** of the release form(s) to our: **DMH Forensic Outpatient Program Email** at fop.dmh@mh.alabama.gov (DO NOT SEND TO INDIVIDUAL EMAIL ADDRESSES) or

Mail to:

Alethea Pittman, JD, MPA
Administrator VI - Forensic Outpatient Services
Alabama Department of Mental Health
Mental Illness & Substance Abuse Services Division
100 North Union Street, Suite 420
Montgomery, AL 36130-1410
fop.dmh@mh.alabama.gov
Phone: 334-242-3732

STEP 3: ***Send original release form(s) and signed court orders to previous treating agency.*** PLEASE MAKE SURE THERE IS A WITNESS TO THE CLIENT'S SIGNATURE ON THE RELEASE FORM.

PLEASE MAKE SURE TO LEGIBLY WRITE/TYPE YOUR CLIENT'S NAME, DOB, AND SSN AT THE TOP OF THE FORM IN THE SECTION INDICATED.

STEP 3 IS THE RESPONSIBILITY OF THE DEFENSE ATTORNEY

COVER SHEET

DEFENDANT'S NAME _____

DEFENDANT'S CURRENT LOCATION: _____ JAIL _____ ON BOND

RACE: _____ SEX: _____ DOB: _____

SOCIAL SECURITY NO. : _____

CONFIRMATION OF CASE NUMBER(S)/CHARGE(S) BY COURT FILE:

CASE NO: _____ CHARGE: _____

CASE NO: _____ CHARGE: _____

CASE NO: _____ CHARGE: _____

JUDGE _____

DISTRICT ATTORNEY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

DEFENSE ATTORNEY: _____

ADDRESS: _____

CITY /ST A TE/ZIP: _____

TELEPHONE: _____

NEXT COURT DATE: _____

Forward Cover Sheet with the following documents to our:

DMH Forensic Outpatient Program Email at fop.dmh@mh.alabama.gov.

Mail to:

Or

Alethea Pittman, JD, MPA
Administrator VI - Forensic Outpatient Services
Alabama Department of Mental Health
Mental Illness & Substance Abuse Services Division
100 North Union Street, Suite 420
Montgomery, AL 36130-1410
fop.dmh@mh.alabama.gov
Phone: 334-242-3732

Alabama Department of Mental Health
Forensic Outpatient Program
RSA Union Building
100 North Union Street, Suite #420
Post Office Box 301410
Montgomery, AL 36130-1410
PHONE: 334-242-3732 **FAX:** 334-242-3025

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: _____

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

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

Previous convictions/pertinent background information _____

Previous psychiatric treatment (PLEASE HAVE DEFENDANT *SIGN* AUTHORIZATION TO RELEASE/RECEIVE PROTECTED HEALTH INFORMATION FORM FOR EACH TREATING AGENCY AND FORWARD ORIGINAL TO THE AGENCY AND A LEGIBLE XEROX COPY TO THE FORENSIC OUTPATIENT PROGRAM); _____

DEFENSE ATTORNEY INFORMATION

SIDE 2

NEXT OF KIN: Name _____ Relationship _____

Complete Address: _____

Telephone Number: _____

Information from relatives, friends, etc., that would clarify defendant's mental condition: _____

_____

_____

_____

_____

Defendant's current location: _____

_____

_____

Date: _____ Attorney: _____

Address: _____

_____

Telephone: _____

Please return this form and copies of Authorization to Release/Receive Protected Health Information form along with pertinent reports/records you may have to:

DMH Forensic Outpatient Program Email at fop.dmh@mh.alabama.gov.

Mail to: Or

Alethea Pittman, JD, MPA
Administrator VI - Forensic Outpatient Services
Alabama Department of Mental Health
Mental Illness & Substance Abuse Services Division
100 North Union Street, Suite 420
Montgomery, AL 36130-1410
fop.dmh@mh.alabama.gov
Phone: 334-242-3732

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: 334-242-3025

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).

IN THE CIRCUIT COURT OF _____ COUNTY, ALABAMA

STATE OF ALABAMA	)	
	)	
vs.	)	CASE NO. _____
	)	
_____,	)	
DEFENDANT.	)	

ORDER FOR PRODUCTION OF RECORDS

I, the undersigned Circuit Judge, do hereby certify that, it 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 in order to execute a court order for outpatient mental evaluation is the basis of this order: Alabama Department of Mental Health, Forensic Outpatient Program;

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 _____, 2018.

_____
Circuit Court Judge

Distribute to:

Alabama Department of Mental Health
Forensic Outpatient Program
100 North Union Street
Post Office Box 301410
Montgomery, Alabama 36130-1410
Email: fop.dmh@mh.alabama.gov
Fax: 1 (334) 242-3025

ATTORNEY TO LIST PREVIOUS TREATMENT AGENCIES BELOW

CLERK TO DISTRIBUTE TO THESE AGENCIES: