

**THE HONORABLE WAYNE A. CHRISTIAN
BEXAR COUNTY VETERANS TREATMENT COURT
300 DOLOROSA, COUNTY COURT-AT-LAW NO.6
SAN ANTONIO, TEXAS 78205
(210) 335-2156**

**CHECKLIST FOR THE VETERANS TREATMENT COURT
APPLICATION:**

- _____ **DD214 Member 4 Copy / Enlisted or Officer Record Brief / Military Service Records**

- _____ **VA Documents (Compensation & Benefits / Disability Rating Bring Breakdown Showing ALL DISABILITIES)**

- _____ **Mental Health and/or substance abuse/dependence treatment records and/ or certificates (Military, VA, and Private Provider)**

- _____ **Photos of you in military uniform (deployment photos are Preferable)**

- _____ **Complete the following questionnaires: TCU Drug Screen, Mental Health Screen, and URICA**

- _____ **VTC Application (Answer ALL questions)**

- _____ **Personal Statement: prepare a typed essay addressing the following:**
 - Why should you be afforded an opportunity to enroll in the VTC program?
 - State that you take full responsibility for any wrongdoing.
 - Explain how you developed your mental health/substance-related problem during your military service and how it contributed to the instant charged offense
 - What role and contributions did you make to the military?
 - What life goals and aspiration do you have?



Acknowledgement of Conditions of the Veterans Treatment Court

Treatment Focus

- I understand that this is a Treatment Focused Program.
- I understand that treatment can include, but is not limited to
 - Inpatient Treatment, Partial Hospitalization, Outpatient Treatment, Groups and Individual Counseling
- I understand that my Case Worker will determine what kind of treatment is appropriate for my individual needs and for what length of time, and it is non-negotiable.
- I understand that although VTC personnel will attempt to work with my schedule, treatment will be a priority over work, school, and other responsibilities.

Probation/ Supervision

- I understand that I will be supervised by a specialized probation officer and I will adhere to the conditions of my supervision. I will report to them as ordered.
- No alcohol, illegal drug, or prescription medication not prescribed to me is allowed whatsoever and I will submit to regular urinalysis testing.
- I understand I will pay for classes according to my criminal offense.
- I understand that for all alcohol related offenses, I will have an alcohol monitoring device for a minimum of half the term of the program and that I will have to pay for the device.
- I will not leave the county without permission and I will submit to searches of my person and residence.

Appearances in Court

- I understand the VTC Docket is held two Mondays each month at 3 PM. I will be provided a copy of the docket schedule.
- I understand I am required to appear to each docket according to my Phase.
- I understand that there are four phases to the program
 - Phase I and Phase II- Appear at each docket (twice a month).
 - Phase III – Appear at the first docket of the month (once a month)
 - Phase IV – No Docket appearance required unless ordered by Probation
- I understand that if I fail to appear at docket a warrant may be issued for my arrest.
- I understand the program is normally one year and there is a \$1,000 VTC program fee.

Signature _____ Date _____

VETERANS TREATMENT COURT APPLICATION

FULL NAME:

DEFENSE ATTORNEY:

DOB/HGT/ WGT/EYES/HAIR/ ETHNICITY/ US CITIZEN:

SSN:

DRIVERS LICENSE#/STATE:

HOME ADDRESS:

CELL PHONE:

EMAIL ADDRESS:

JOB POSITION:

WORK ADDRESS:

MARITAL STATUS/CHILDREN:

EDUCATIONAL LEVEL/DEGREES:

PENDING CRIMINAL CHARGES/VICTIMS RESTITUTION: See attached CJIS print out.

<u>Arrest Date</u>	<u>Cause No.</u>	<u>Charge</u>	<u>Court</u>	<u>Disposition</u>
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CASE#/COURT/COUNTY:

CURRENT SETTING DATE:

FRIEND/ADDRESS/PHONE:

CRIMINAL HISTORY/DATES/STATES/COURTS/CASE#'S/DISPOSITION:

SPECIFIC PROBLEM DRUGS/SUBSTANCES:

MILITARY SERVICE/BRANCH/RANK/ ACTIVE/RESERVE/DATES:

DISCHARGE TYPE/DD214:

MILITARY OCCUPATIONAL SPECIALTY/ JOB POSITION/ DUTIES:

HOSTILE FIRE ZONE EXPOSURE/ DATES/ UNITS/ JOB POSITION/ LOCATIONS:

AWARDS & DECORATIONS/ AWARD CITATIONS/ LETTERS:

UCMJ DISCIPLINARY ACTIONS/ARTICLE 15's/ COURTMARTIAL:

MILITARY & CIVILIAN REHABILITATION & COUNSELING PROGRAMS:

WIA DATES& LOCATION/MEDICAL STATUS/DISABILITIES/MENTAL/PHYSICAL:

CURRENT MEDICATION/PROGRAMS:

MEDICAL RECORDS/HIPPA RELEASE/WAIVER:

(%) VA DISABLED VETERAN/ MONTHLY PAYMENTS RECEIVED:

PHOTOGRAPH OF APPLICANT DEPICTING THEIR MILITARY SERVICE:

FUTURE GOALS AND ASPIRATIONS OF APPLICANT:

SOCIAL SERVICES NEEDED/REQUESTED (Transportation, Utility Assistance, Temp Housing)

INCOME:

ACTIVE DUTY: IS YOUR COMMAND AWARE?

IF YES, PLEASE PROVIDE YOUR COMMANDS NAME, PHONE NUMBER , AND ADRESS OF POINT OF CONTACT.

Guidelines for Using the Mental Health Screening Form III

The Mental Health Screening Form-III (MHSF-III) was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either "yes" or "no." All questions reflect the respondent's **entire life history**; therefore all questions begin with the phrase "Have you ever..."

The **preferred** mode of administration is for staff members to read each item to the respondent and get their "yes" and "no" responses. Then, **after** completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "When did this problem first develop?"; "How long did it last?"; "Did the problem develop **before, during, or after** you started using substances?"; and, "What was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to clients for them to complete, providing they have sufficient reading skills. If there is any doubt about someone's reading ability, have the client read the MHSF-III instructions and question number one to the staff member monitoring this process. If the client can not read and/or comprehend the questions, the questions must be read and/or explained to him/her.

Whether the MHSF-III is read to a client or s/he reads the questions and responds on his/her own, the completed MHSF-III **should be carefully reviewed** by a staff member to determine how best to use the information. It is strongly recommended that a **qualified mental health specialist** be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine whether or not a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a "Total Score" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, **questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories:** Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Post-Traumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; Q12, Eating Disorders (Anorexia, Bulimia); Q13, Manic Episode; Q14, Panic Disorder; Q15, Obsessive-Compulsive Disorder; Q16, Pathological Gambling; Q17, Learning Disorder and Mental Retardation.

The relationship between the diagnoses/diagnostic categories and the above cited questions was investigated by having four mental health specialists independently "select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories." All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as we have noted in the preceding paragraph.

A "yes" response to any of questions 5 through 17 does **not**, by itself, insure that a mental health problem exists at this time. A "yes" response raises only the **possibility** of a **current** problem, which is why a consult with a mental health specialist is strongly recommended.

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –“Have you ever”

- | | | |
|---|-----|----|
| 1) Have you <u>ever</u> talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? | YES | NO |
| 2) Have you <u>ever</u> felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? | YES | NO |
| 3) Have you <u>ever</u> been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? | YES | NO |
| 4) Have you <u>ever</u> been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? | YES | NO |
| 5) Have you <u>ever</u> heard voices no one else could hear or seen objects or things which others could not see? | YES | NO |
| 6) a) Have you <u>ever</u> been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? | YES | NO |
| b) Did you <u>ever</u> attempt to kill yourself? | YES | NO |
| 7) Have you <u>ever</u> had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? | YES | NO |
| 8) Have you <u>ever</u> experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? | YES | NO |
| 9) Have you <u>ever</u> given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? | YES | NO |

- 10) Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO
- 11) Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO
- 12) Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO
- 13) Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO
- 14) Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO
- 15) Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES NO
- 16) 1. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO
- 17) Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES NO

Print Client's Name: _____ Program to which client will be assigned: _____

Name of Admissions Counselor: _____ Date: _____

Reviewer's Comments: _____

Scoring for the TCU Drug Screen II

Page 1 of the TCU Drug Screen is scored as follows:

1. Give 1-point to each "yes" response to 1-9
(Questions 4 and 6 are worth one point each if a respondent answers "yes" to any portion).
2. The total score can range from 0 to 9; score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis.
3. Responses to Question 10 indicate which drug (or drugs) the respondent feels is primarily responsible for his or her drug-related problems.

The TCU Drug Screen II was developed as part of NIJ Grant 1999-MU-MU-K008, *Assessment of a Drug Screening Instrument*.

The TCU Drug Screen II may be used for personal, educational, research, and/or information purposes. Permission is hereby granted to reproduce and distribute copies of the form for nonprofit educational and nonprofit library purposes, provided that copies are distributed at or below costs and that credit for author, source, and copyright are included on each copy. No material may be copied, downloaded, stored in a retrieval system, or redistributed for any commercial purpose without the expressed written permission of Texas Christian University.

For more information on the TCU Drug Screen II, please contact:

Institute of Behavioral Research
Texas Christian University
TCU Box 298740
Fort Worth, TX 76129
(817) 257-7226
(817) 257-7290 FAX
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Web site: www.ibr.tcu.edu

EACH STATEMENT BELOW DESCRIBES A HOW A PERSON MIGHT FEEL WHEN STARTING THERAPY OR APPROACHING PROBLEMS IN THEIR LIVES. PLEASE INDICATE THE EXTENT TO WHICH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR WOULD LIKE TO FEEL. FOR ALL STATEMENTS THAT REFER TO YOUR "PROBLEM", ANSWER IN TERMS OF PROBLEMS RELATED TO YOUR ILLEGAL DRUG USE. THE WORDS "HERE" AND "THIS PLACE" REFER TO YOUR TREATMENT CENTER.

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS IN THE QUESTIONNAIRE:

- 1=Strongly Disagree**
- 2=Disagree**
- 3=Undecided**
- 4=Agree**
- 5=Strongly Agree**

CIRCLE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) I'm not the problem one. It doesn't make much sense for me to consider changing.	1	2	3	4	5
2) I am finally doing some work on my problem.	1	2	3	4	5
3) I've been thinking that I might want to change something about myself.	1	2	3	4	5
4) At times my problem is difficult, but I'm working on it.	1	2	3	4	5
5) Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
6) I'm hoping that I will be able to understand myself better.	1	2	3	4	5
7) I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
8) I am really working hard to change.	1	2	3	4	5
9) I have a problem and I really think I should work on it.	1	2	3	4	5
10) I'm not following though with what I had already changed as well as I had hoped, and I want to prevent a relapse of the problem.	1	2	3	4	5

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
11) Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
12) I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
13) I wish I had more ideas on how to solve my problem.	1	2	3	4	5
14) Maybe someone or something will be able to help me.	1	2	3	4	5
15) I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
16) I may be part of the problem, but I don't really think I am.	1	2	3	4	5
17) I hope that someone will have some good advice for me.	1	2	3	4	5
18) Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
19) All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
20) I'm struggling to prevent myself from having a relapse of my problem.	1	2	3	4	5
21) It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
22) I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
23) I am actively working on my problem.	1	2	3	4	5
24) After all I had done to try and change my problem, every now and then it comes back to haunt me.	1	2	3	4	5

URICA 24 Item Versions:

	Precontemplation	Contemplation	Action	Maintenance
Question Numbers	1	3	2	10
	5	6	4	12
	7	9	8	15
	16	13	11	20
	19	14	18	21
	22	17	23	24
Total:				
Divide by:	6	6	6	6
Mean:				

In order to obtain a Readiness to Change score, first sum items from each subscale and divide by 6 to get the mean for each subscale. Then sum the means from the Contemplation, Action, and Maintenance subscales and subtract the Precontemplation mean ($C + A + M - PC = \text{Readiness}$).

Cut-off scores can be created for the readiness score but it is important to consider your population and how conservative you want to be. Cut-off scores are essentially arbitrary and you should be thinking about the stages as least ready, middle and most ready. For the general population, the following cut-off scores may be appropriate:

8 or lower classified as **Precontemplators**

8-11 classified as **Contemplators**

11-14 classified as **Preparators into Action Takers**

For intensive service populations, it may be more appropriate to use only score in the range of 12-14 to classify those in preparation and action.

Client ID#	Today's Date	Facility ID#	Zip Code	Administration
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TCU Drug Screen V

During the last 12 months (before being locked up, if applicable) –

	No	Yes
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	<input type="radio"/>	<input type="radio"/>
2. Did you try to control or cut down on your drug use but were unable to do it?	<input type="radio"/>	<input type="radio"/>
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	<input type="radio"/>	<input type="radio"/>
4. Did you have a strong desire or urge to use drugs?	<input type="radio"/>	<input type="radio"/>
5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	<input type="radio"/>	<input type="radio"/>
6. Did you continue using drugs even when it led to social or interpersonal problems? ...	<input type="radio"/>	<input type="radio"/>
7. Did you spend less time at work, school, or with friends because of your drug use?	<input type="radio"/>	<input type="radio"/>
8. Did you use drugs that put you or others in physical danger?	<input type="radio"/>	<input type="radio"/>
9. Did you continue using drugs even when it was causing you physical or psychological problems?	<input type="radio"/>	<input type="radio"/>
10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	<input type="radio"/>	<input type="radio"/>
10b. Did using the same amount of a drug lead to it having less of an effect as it did before?	<input type="radio"/>	<input type="radio"/>
11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	<input type="radio"/>	<input type="radio"/>
11b. Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	<input type="radio"/>	<input type="radio"/>
12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]		
<input type="radio"/> None <input type="radio"/> Alcohol <input type="radio"/> Cannabinoids – Marijuana (weed) <input type="radio"/> Cannabinoids – Hashish (hash) <input type="radio"/> Synthetic Marijuana (K2/Spice) <input type="radio"/> Opioids – Heroin (smack) <input type="radio"/> Opioids – Opium (tar) <input type="radio"/> Stimulants – Powder Cocaine (coke) <input type="radio"/> Stimulants – Crack Cocaine (rock) <input type="radio"/> Stimulants – Amphetamines (speed)	<input type="radio"/> Stimulants – Methamphetamine (meth) <input type="radio"/> Bath Salts (Synthetic Cathinones) <input type="radio"/> Club Drugs – MDMA/GHB/Rohypnol (Ecstasy) <input type="radio"/> Dissociative Drugs – Ketamine/PCP (Special K) <input type="radio"/> Hallucinogens – LSD/Mushrooms (acid) <input type="radio"/> Inhalants – Solvents (paint thinner) <input type="radio"/> Prescription Medications – Depressants <input type="radio"/> Prescription Medications – Stimulants <input type="radio"/> Prescription Medications – Opioid Pain Relievers <input type="radio"/> Other (specify) _____	

13. How often did you use each type of drug during the last 12 months?	Never	Only a few Times	1-3 Times per Month	1-5 Times per Week	Daily
a. Alcohol	<input type="radio"/>				
b. Cannabinoids – Marijuana (weed).....	<input type="radio"/>				
c. Cannabinoids – Hashish (hash)	<input type="radio"/>				
d. Synthetic Marijuana (K2/Spice)	<input type="radio"/>				
e. Opioids – Heroin (smack)	<input type="radio"/>				
f. Opioids – Opium (tar)	<input type="radio"/>				
g. Stimulants – Powder cocaine (coke)	<input type="radio"/>				
h. Stimulants – Crack Cocaine (rock)	<input type="radio"/>				
i. Stimulants – Amphetamines (speed)	<input type="radio"/>				
j. Stimulants – Methamphetamine (meth)	<input type="radio"/>				
k. Bath Salts (Synthetic Cathinones)	<input type="radio"/>				
l. Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)	<input type="radio"/>				
m. Dissociative Drugs – Ketamine/PCP (Special K)	<input type="radio"/>				
n. Hallucinogens – LSD/Mushrooms (acid)	<input type="radio"/>				
o. Inhalants – Solvents (paint thinner)	<input type="radio"/>				
p. Prescription Medications – Depressants	<input type="radio"/>				
q. Prescription Medications – Stimulants	<input type="radio"/>				
r. Prescription Medications – Opioid Pain Relievers	<input type="radio"/>				
s. Other (specify) _____.....	<input type="radio"/>				

14. How many times before now have you ever been in a drug treatment program?

[DO NOT INCLUDE AA/NA/CA MEETINGS]

- Never* *1 time* *2 times* *3 times* *4 or more times*

15. How serious do you think your drug problems are?

- Not at all* *Slightly* *Moderately* *Considerably* *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

- Never* *Only a few times* *1-3 times/month* *1-5 times per week* *Daily*

17. How important is it for you to get drug treatment now?

- Not at all* *Slightly* *Moderately* *Considerably* *Extremely*



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 24VA10P2 "Patient Medical Record - VA" and in accordance with the 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)

STVHCS

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

Veterans Treatment Court Judge, Staff, Probation Officers, Attorneys, and any/all Guests of the Veterans Court.

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 Initial Assessment, DX, Medications, TX Plan, UA results, Attendance, and DC Summaries, past & future, related to court directed tx. Reporting of progress during the course of tx

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

To provide the VTC with a current status of the Veteran's tx which will require records created after the signature of this authorization. Verbal reports to VTC are also authorized with this ROI.

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):

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