Brooklyn Mental Health Court
Brooklyn Supreme Court
320 Jay Street 14th Floor
Brooklyn, New York

CONSENT FOR RELEASE OF INFORMATION
CONCERNING MEDICAL/SURGICAL,
ALCOHOLISM/DRUG ABUSE
AND/OR PSYCHIATRIC PATIENT

Name of Patient (Last)	(First)	(MI)
Address	Birth Date	

Authorization for the BROOKLYN MENTAL HEALTH COURT and staff thereof to receive from and exchange information with:	

Extent or nature of information to be disclosed

Purpose or need for information

I have read the above and authorize the staff of the disclosing facility named to disclose such information either in writing, by copy of medical records, or by telephone as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire one year from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply.

I authorize the staff of the Brooklyn Mental Health Court to redisclose this information (1) to my defense attorney and the Kings County District Attorney's Office for purposes of establishing my eligibility for participation in the Brooklyn Mental Health Court and preparing a treatment plan and (2) to any treatment, housing or case management providers who might be providing services to me if I become a participant in the Brooklyn Mental Health Court for the purpose of arranging such services. I understand that the release of any patient records or the redisclosure of this information to a party other than the ones indicated above is forbidden without additional written authorization on my part.

I understand that the information being disclosed may include HIV-related information, and I consent to this disclosure as well. If the information disclosed includes HIV-related information, then this information may not be shared with persons and organizations other than those stated above.

Signature of Patient/Participant	Print Name of Patient/Participant	Date
Signature of Patient/Guardian (when required)	Print Name of Patient/Guardian	Date
Signature of Witness	Print Name of Witness	Date