OFFICE OF THE JOHNSON COUNTY KANSAS DISTRICT ATTORNEY
STEPHEN HOWE, DISTRICT ATTORNEY
MENTAL HEALTH DIVERSION UNIT
100 N Kansas PO BOX 728 Olathe, KS 66061 | PH 913.715.3114 FX 913.715.3040

OUT-OF-COUNTY RESIDENT MENTAL HEALTH DIVERSION INFORMATION FORM AND AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY BY YOU AND YOUR MENTAL HEALTH TREATMENT PROVIDER AND SUBMITTED WITH THE DIVERSION APPLICATION OR THE APPLICATION WILL BE DENIED.

TO BE COMPLETED BY DEFENDANT

_____ _____ _____
Defendant's Full Name Date of Birth Case Number

I, Defendant, am engaged in Mental Health Treatment with _____ ("Provider") and I hereby authorize Provider to disclose, verbally and in writing, Protected Health Information, including but not limited to, Acknowledgement of Treatment, Diagnoses, Discharge/Summary Plans, Intake/Admission Information, Medications Administered/Prescribed, Plan of Care/Treatment Plan, Progress Notes, Psychiatric Evaluations/Reports, and Monthly Compliance Reports relating to my Mental Health and/or Substance Abuse Treatment, to the Johnson County District Attorney's Office Mental Health Diversion Unit for the purposes of determining eligibility for Mental Health Diversion and, if granted, to monitor my treatment during my diversion term, and I further authorize Provider to provide court testimony regarding the same.

_____
Defendant's Signature/Date

TO BE COMPLETED BY PROVIDER

Provider may attach a summary to answer any of the questions below.

Provider Name and Address: _____
_____
Provider Email: _____
Provider Telephone: _____
Provider Fax: _____
Date Defendant began mental health treatment with you _____
Defendant's Current Diagnoses _____
Please explain how Defendant's diagnoses correlate with the offence with which Defendant has been charged:
_____
_____
_____
Please describe treatment plan for the Defendant: _____
_____
_____

I hereby agree to provide mental health services for the above Defendant for the entire term of diversion if granted and send a monthly compliance report by the 10th of each month to the Mental Health Diversion Unit.

_____
Provider Signature/Date