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

CONSENT FOR RELEASE OF INFORMATION		Name of Patier	nt	
CONCERNING MEDICAL/SURGICAL,		(Last)	(First)	(MI)
ALCOHOLISM/DRUG ABUSE AND/OR PSYCHIATRIC PATIENT				
AND/OR F3 TOMATRIC PATIENT	*	Address		Birth Date
		7.00.000		
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Authorization for the BROOKLYN MENTAL HEALTI and staff thereof to receive from and exchange info				
and stall thereof to receive from and exchange into	imatioji witti.			
Extent or nature of information to be disclosed				
Purpose or need for information		* · · · · · · · · · · · · · · · · · · ·		
I have read the above and authorize the staff of the of medical records, or by telephone as herein contai except to the extent that action has been taken in re a different time period, event or condition is specified	ned. I understa liance upon it.	nd that this cons This consent sha	ent may be witho all expire one yea	lrawn by me at any time r from its signing, unless
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I authorize the staff of the Brooklyn Mental Health C County District Attorney's Office for purposes of esta				
and preparing a treatment plan and (2) to any treatment				
me if I become a participant in the Brooklyn Mental H	Health Court for	the purpose of a	irranging such se	rvices. I understand that the
release of any patient records or the redisclosure of without additional written authorization on my part.	this information	to a party other	than the ones inc	licated above is forbidden
without additional written authorization on my part.				
I understand that the information being disclosed mathe information disclosed includes HIV-related informother than those stated above.				
Signature of Patient/Participant Print Na	me of Patient/P	articipant		Dale
Signature of Detiont/Cuardian	ma of Dationt/C	dian		 Date
Signature of Patient/Guardian Print Na (when required)	me of Patient/G	iualUlall		Jaic
(/				
Signature of Witness	mo of Mitagas			Date
Signature of Witness Print Na	me of Witness		ı	Jaic