SAN DIEGO JUVENILE COURT
PROCEDURE TO OBTAIN AUTHORIZATION TO USE OR DISCLOSE
PROTECTED MENTAL HEALTH INFORMATION
FOR EVALUATIONS OF MINORS IN CUSTODY

I. INTRODUCTION

When the juvenile court orders a psychological or psychiatric evaluation[1] (hereafter evaluation) in a delinquency case, a TERM-approved probation evaluator is normally assigned to perform the evaluation. The evaluator would like to be able to review the minor's medical and mental health records as part of the evaluation process. Due to the short timelines for evaluations of minors in custody, this procedure has been developed to facilitate the process of obtaining authorization to disclose the following information: (1) The minor's current psychiatric medications and dates of first prescription, if known; (2) The minor's current non-psychiatric medications, and dates of prescription, if known; (3) The minor's prior psychiatric medications, and dates of prescription, if known; (4) The minor's psychiatric diagnosis (diagnoses) along with the dates those diagnoses were initially noted in the record; (5) Any current serious medical problems which may be impacting the minor's mood or behavior; (6) Whether or not the minor has ever been on suicide watch, along with the dates and precipitating behaviors leading to the suicide watch; and (7) Whether or not the record indicates that the minor has ever been psychiatrically hospitalized, and the dates of hospitalization, if known.

II. AUTHORIZATION BY MINOR

A. A minor who is 12 years of age or older and not the subject of a dependency petition may consent to certain types of medical treatment, including mental health services. If the minor consents to the treatment, the minor must also sign the authorization to use or disclose information.

B. When the court orders the evaluation, the minor will be provided with the Authorization to Use or Disclose Protected Health Information (HHSA 23-07) in court if s/he is 12 years old or older. The minor's attorney will explain the purpose of the authorization to the minor. The minor may either sign the authorization or write "Declined to sign" in the signature box.

C. The court officer will deliver the authorization to the Probation Aide. After the evaluation is assigned, the Probation Aide or the assigned Probation Officer will write the evaluator's name and contact information on page 1 of the authorization in the section that says THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION. The authorization will be included in the packet that is provided to the evaluator.

D. The evaluator will present the authorization to obtain access to the minor's mental health records.

[1] This procedure does not apply to mental competence evaluations.

III. PARENT OR GUARDIAN PRESENT WHEN EVALUATION ORDERED

A. When the minor is given the authorization to sign, the court will tell the parent/guardian what the minor is signing. If the minor is under the age of 12, the court will order the parent/guardian to report to Window A when an evaluation is ordered.

B. At Window A, the Family Advocate will provide the parent/guardian with the authorization and will explain its purpose. The parent/guardian may either sign the form or write "Declined to sign" in the signature box.

C. The Family Advocate will deliver the form to the Probation Aide.

D. After the evaluation is assigned, the Probation Aide or the assigned Probation Officer will write the evaluator's name and contact information on page 1 of the authorization in the section that says THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION. The authorization will be included in the packet that is provided to the evaluator.

E. The evaluator will present the authorization to obtain access to the minor's mental health records.

IV. DUAL JURISDICTION CASES

A. If the minor is already a dependent or if a 300 petition has been filed, the authorization must be signed by the minor's dependency attorney. When the court orders an evaluation for a minor who is the subject of a dependency petition and the dependency attorney is present in court, the attorney will either sign the authorization or write "Declined to sign" in the signature box. The court officer will deliver the authorization to the assigned Probation Officer.

B. If the dependency attorney was not present in court, the assigned Probation Officer will fax the authorization to the Dependency Legal Group (DLG) at 619-795-1074 with a cover sheet that states "Authorization to disclose information for evaluation requested. Requires immediate attention." Within two court days, the DLG attorney will sign the authorization or write "Declined to sign" in the signature box and fax the authorization back to the Probation Officer.

C. After the evaluation is assigned, the Probation Officer will write the evaluator's name and contact information on page 1 of the authorization in the section that says THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION. The authorization will be included in the packet that is provided to the evaluator.[2]

D. The evaluator will present the authorization to obtain access to the minor's mental health records.

[2] If the packet is ready to be sent to the evaluator and the DLG attorney has not yet returned the authorization, the packet will be sent without the authorization. The authorization will be sent to the evaluator as soon as it is received from DLG.

V. NO AUTHORIZATION FORM IN PACKET

If there is no authorization form in the packet that is provided to the evaluator, the evaluator will have to obtain the necessary signature(s) on the authorization before s/he will be allowed to look at the mental health records maintained by the STAT Team. The evaluator will be allowed to review the medical records maintained by the CFMG upon presentation of a document showing that the evaluation has been assigned to him/her (referral form or court order or authorization).

VI. ROLE OF THE DEFENSE ATTORNEY

The minor's defense attorney will advise the minor about the purpose of the authorization before the minor signs it. The attorney will not play a role in obtaining a signed authorization from a parent/guardian. In any case, the evaluator can and should contact the defense attorney, as the attorney usually can provide information that would be helpful to the evaluator.

ATTACHMENT

WHERE TO OBTAIN RELEVANT INFORMATION

· **The minor's current psychiatric medications and dates of first prescription, if known:** STAT can provide the current medications and may or may not be able to provide the date of first prescription.

· **The minor's current non-psychiatric medications and dates of first prescription, if known:** Get this information from the CFMG medical clinic.

· **The minor's prior psychiatric medications, and dates of prescription, if known:** STAT may or may not be able to provide this information.

· **The minor's psychiatric diagnosis (diagnoses) along with the dates those diagnoses were initially noted in the record:** STAT can provide the current diagnosis, may not be able to provide the date it was noted in the record.

· **Any current serious medical problems which may be impacting the minor's mood or behavior:** STAT may or may not be able to provide this information, but it should be available from the CFMG medical clinic.

· **Whether or not the minor has ever been on suicide watch, along with the dates and precipitating behaviors leading to the suicide watch:** STAT can usually provide this if the minor was on suicide watch within the last two weeks, but not prior to that.

· **Whether or not the record indicates that the minor has ever been psychiatrically hospitalized, and the dates of hospitalization, if known:** STAT will not have this information.

· **For Firesetting evaluations: Whether or not the record indicated any history of firesetting, and age of the minor at the time of the firesetting, if known:** STAT will not have this information.

· **For Violence Risk evaluations: Whether or not the record contains confirmed records of violent actions against persons while the minor has been in custody and the dates of reported violent actions:** Get this information from Probation.

· **Inpatient discharge summaries and copies of previous psychological evaluations when available:** Get this information from Probation or minor's counsel.

STAT Team office (Kearny Mesa Juvenile Detention Facility): **858-694-4752**
STAT Team clinic hours: Monday through Friday 8:30 am to 4:30 pm (Occasionally there will not be anyone in the office during "clinic hours" as a result of a staff meeting, so call before heading over.)

CFMG medical clinic office (Kearny Mesa Juvenile Detention Facility): **858-694-4690**
CFMG medical clinic hours: 24/7 (Call ahead so that staff may pull the file and be ready for your visit.)

COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

			DATE:
PATIENT/RESIDENT/CLIENT			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN (OPTIONAL):	DATE OF BIRTH:	
AKA'S:			
THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.			
LAST NAME OR ENTITY: County of San Diego Juvenile Forensics STAT Team		FIRST NAME:	MIDDLE INITIAL:
ADDRESS 2801 Meadowlark Dr.		CITY/STATE: San Diego, CA	ZIP CODE: 92123
TELEPHONE NUMBER: (858)694-4752		DATE:	
THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION.			
LAST NAME OR ENTITY:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:		DATE:	

TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☒ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☒ Other *(Provide description)* Any serious medical problems that impact mood or behavior AND/OR Psychiatric diagnoses and recent suicide watches.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information

from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have the right to receive a copy of this authorization. I would like a copy of this authorization. ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

VALIDATE IDENTIFICATION ☐	
SIGNATURE OF STAFF PERSON:	DATE: