



Dallas County Criminal Justice Department PRE-TRIAL DIVERSION REFERRAL FORM

Date of Referral	Current Court:		
Referred by:			
Defendant Information			
Defendant Name			
	Last	First	Middle
DOB	Gender		
Race	Ethnicity		
Language			
Defendant Email:			
Defendant Phone:			
Case and Charge Information (please list all cases and charges, felony and misdemeanor)			
Case #	Offense	Indictment Date	
Case #	Offense	Indictment Date	
Case #	Offense	Indictment Date	
Case #	Offense	Indictment Date	
Case #	Offense	Indictment Date	
Case #	Offense	Indictment Date	
Bond <input type="checkbox"/>	Jail <input type="checkbox"/>	If Jail, Booking No.	
Defense Attorney Information			
Name			
Bar No.	Phone:		
Email:			

Please send Pre-Trial Diversion Referral Form to Jaildiversion@dallascounty.org and attach AUTHORIZATION FOR ASSESSMENT PRETRIAL DIVERSION FORM signed by Defense Attorney



**DEPARTMENT OF CRIMINAL JUSTICE
AUTHORIZATION FOR ASSESSMENT
PRETRIAL DIVERSION**

Defendant Name:	Age:
Book-in Number:	Gender:
DOB:	Race/Ethnicity:
Case No.:	Primary Language:
Email:	Phone: Alt No.:

Authorization by Defense Attorney

I acknowledge that I was contacted by the Dallas County Criminal Justice Division and that I agree that my client identified above may proceed to be assessed by the Dallas County Criminal Justice Division in order to be considered for possible case diversion.

Attorney Printed Name:	Signature:
TX Bar Number:	Date:

Authorization by Defendant

I waive my rights of confidentiality and authorize any Dallas County Criminal Justice Department personnel to request and receive information or records from any person including myself, or any agency specified below having information or records concerning my medical, psychological or psychiatric history and any information or records pertaining to diagnosis, condition or treatment of a medical, psychological or psychiatric nature including acquired immune deficiency syndrome (AIDS), human immunodeficiency viral infection (HIV) or any AIDS related complex.

I further waive my rights of confidentiality and authorize below agency, doctor, hospital, or treatment facility to disclose any and all information or records requested by any Dallas County Criminal Justice Department personnel.

- Family: _____ Phone: _____ Relationship: _____
- Family: _____ Phone: _____ Relationship: _____
- Other: _____ Phone: _____ Relationship: _____
- Other: _____ Phone: _____ Relationship: _____
- Physician: _____ Phone: _____ Fax: _____

I further waive my rights of confidentiality and authorize Dallas County Criminal Justice Department personnel to disclose any and all acquired information or records to the following:

1. The Judge having authority over my case and the personnel of the Court.
2. Other Dallas County Community Supervision and Corrections Department involved in the supervision and maintenance of my supervision file.
3. Personnel of any department to which my case may be transferred for supervision.
4. Personnel of any residential facility in which I may be placed, including the Dallas County Judicial Treatment Center.

5. Personnel of any institution facility to which I may be committed.
6. Personnel of any treatment/diagnostic program to which I may be assigned.
7. Personnel from the District Attorney's office.
8. My attorney of record.
9. Texas Department of Criminal Justice, Community Justice Administrative Division.

I understand one purpose of, and need for, this disclosure is to inform the Dallas County Criminal District Attorney's Office and my Attorney of Record of my **eligibility** for pre-trial intervention diversion programs or post indictment plea bargain offers, including treatment recommendations. This information may be released through verbal, written or electronic communication.

I understand **the assessment will be made available to** the Dallas County Criminal Justice Department, the Dallas County Criminal District Attorney's Office and my Attorney of Record; however, should any facts pertaining to the underlying offense be disclosed during the assessment, such facts shall be redacted from the assessment and not be made available to the State nor shall such facts be used in the prosecution of the case.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient records and that recipients of the information may re-disclose it only in connection with their official duties.

I have read or have had read to me the terms and conditions of this agreement and fully understand same. I do hereby freely, knowingly, and intelligently agree to those terms and conditions.

EMERGENCY/ALTERNATE CONTACT

In the event of an emergency, or in the event that Criminal Justice Department is unable to contact me, I authorize Criminal Justice Department to contact the person below:

Name: _____ Phone: _____ Relationship: _____
 Address: _____ Apt No.: _____ City: _____ Zip: _____

This authorization is valid for 1 year from the date it is signed. This authorization will expire on _____

Signature: _____ **Date:** _____

Right to Revoke

I understand that I may revoke this authorization in writing at any time, except to the extent that the Department of Criminal Justice has relied on this authorization to use or disclose my information for the purposes solely disclosed above.

Notice to Prohibit Re-disclosure of Confidential Information

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization to Refer to Peer Recovery Support

This authorization allows for personal identifying information to be shared with the Association of Persons Affected by Addiction (APAA), for the purposes of referring me to a Recovery Coach.

A Recovery Coach is an individual with lived experience with a substance use disorder and/or mental health challenges. The Recovery Coach will aid in helping with engagement in recovery.

I understand that the following information may be shared with APAA for the purposes of a referral to a Recovery Coach:

- Name
- Date of Birth
- Current location (jail or address in the community)
- Contact information
- Current Criminal Offense Charge (no details of offense, just name of charge only) & Current Pretrial Diversion program recommendation

I understand that it is voluntary for me to engage with the APAA Recovery Coach. I understand that no personal information related to my substance use history, mental health, physical health, or criminal offense and/or criminal history will be shared by the APAA Recovery Coach with the Dallas County court system unless subject to court subpoena, or unless I give permission for information to be shared.

By giving authorization, I am allowing APAA to share my name with the Dallas County Criminal Justice Department that I am electing to engage in Recovery Coaching services. Information provided will include name, date of birth, date service engagement began, and date service engagement ended. This information will not be shared by the Dallas County Criminal Justice Department and is only collected for the purposes of gathering data to provide aggregate information for grant reporting. No identifying information will be part of submitted grant reporting.

This authorization is valid for 1 year from the date it is signed. This authorization will expire on _____

Signature: _____

Date: _____

Notice to Prohibit Re-disclosure of Confidential Information

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Right to Revoke

I understand that I may revoke this authorization in writing at any time, except to the extent that the Department of Criminal Justice has relied on this authorization to use or disclose my information for the purposes solely disclosed above.

CAUSE NO. _____

THE STATE OF TEXAS

§
§
§
§
§

IN THE JUDICIAL/CRIMINAL

VS.

DISTRICT COURT # _____

DALLAS COUNTY, TEXAS

**DEFENSE’S CCPART. 39.14 & HEATH WAIVER FOR PRE-TRIAL
DIVERSION/MENTAL HEALTH REFERRAL**

1. When referring to diversion, the Defendant waives the right to additional discovery beyond materials already provided, acknowledging receipt of all necessary information to enter into the pretrial diversion agreement.
2. The State retains control over a database containing potentially exculpatory or mitigating information related to personnel involved in the case.
3. Although disclosure of this information might be required under *Brady v. Maryland* and CCP Article 39.14, the defendant voluntarily waives the right to request an inquiry of the database for personnel involved.
4. This waiver is executed without coercion and is independent of the pretrial diversion agreement.
5. Upon diversion failure, the waiver is voided, and discovery resumes under normal prosecutorial protocols.
6. The defense agrees that the pause in discovery requests and inquiries, absent new evidence received during diversion, will not be held against the assigned court prosecutor should the case be returned to the court for disposition.
7. Upon successful completion of diversion, defense attorney will notify and recommend that defendant apply for immediate expunction.
8. Pursuant to *State of Texas v. Dwayne Robert Heath*, as decided by the Texas Court of Criminal Appeals, the attorney acknowledges that any documents submitted to the State for any reason must be disclosed to the defense attorney in the event the defendant fails to complete the diversionary process, and the case(s) are returned to the original court or division.
9. Furthermore, any documents submitted to the Restorative Justice/Mental Health Division may be disclosed to the defense attorney if the defendant is ever charged with a new case in the future or becomes a complaining witness in a future case.
10. Finally, the attorney acknowledges that the above examples are not exhaustive; other situations not explicitly outlined here may also fall under the Heath ruling and require disclosure.

I consent to the above waiver, have read CCP Art. 39.14 and the Heath disclosure, and understand that any document submitted to the State is subject to the discovery requirements outlined in Heath. By signing below, I acknowledge my understanding and agreement with these terms:

Defense Attorney Name (printed)

Defense Attorney's Signature

Date

Defendant's Signature

Date