IN THE CIRCUIT COURT OF _____ COUNTY, ARKANSAS

_____DIVISION

STATE OF ARKANSAS

VS CASE NO. :_____

_____ _____ _____ _____

(FULL NAME OF DEFENDANT) Date of Birth Sex Race

_____

OFFENSE(S) CHARGED AND CODE NOS.:

_____

PROSECUTING ATTORNEY'S NAME AND ADDRESS:

_____

DEFENSE ATTORNEY'S NAME AND ADDRESS:

_____

NAME OF ATTORNEY REQUESTING EXAMINATION:

_____

ARKANSAS ARREST TRACKING NUMBER:

_____

DEFENDANT'S CUSTODY STATUS AND LOCATION:

ORDER FOR CRIMINAL RESPONSIBILITY EXAMINATION OF DEFENDANT

Pursuant to Ark. Code Ann. § 5-2-304, the defendant has filed notice that he/she intends to rely on the defense of lack of criminal responsibility and _____ has petitioned the Court for a criminal-responsibility examination and opinion.

☐ The court finds the defendant fit to proceed.

It is therefore ORDERED:

1. All further proceedings in the prosecution are immediately suspended.
2. The defendant shall undergo examination by one (1) or more disinterested qualified psychiatrists or qualified psychologists.
3. The moving party or _____, as designated by the Court, shall email a copy of this Order to the Director of the Division of Aging, Adult, and Behavioral Health Services [DAABHS] Director of Forensic Services at Forensics@dhs.arkansas.gov . If DAABHS is not conducting the evaluation, the moving party or_____, as designated by the Court, shall provide a copy of this order to the examiner selected by this court.
4. The prosecuting attorney shall provide the examiner any information relevant to the examination, including but not limited to:
    A. The name and address of any attorney involved in the matter;
    B. Information about the alleged offense (s); and
    C. Any information about the defendant's background that is determined to be relevant to the examination, including the criminal history of the defendant.
5. Defense counsel shall provide the following information to the examiner:

A. psychiatric records,

B. medical records,

C. records pertaining to treatment of the defendant for substance or alcohol abuse; and/or

D. either a release of protected health information, signed by the defendant, with a list of all known previous healthcare providers; or, if the defendant cannot provide consent, a court order for the production of records.

Additional information as identified below:

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6. An examination report prepared by the examiner shall include the following:

A. A description of the nature of the examination;

B. An opinion as to whether as the result of a mental disease or defect the defendant at the time of the alleged offense lacked the capacity to appreciate the criminality of his or her conduct or to conform his or her conduct to the requirements of law, an explanation of the examiner's opinion, and the basis of the opinion; and

C. _☐_ (check if required) An opinion as to whether at the time of the alleged offense the defendant lacked the capacity to form a culpable mental state that is required to establish an element of the alleged offense with an explanation of the examiner's opinion and the basis of the opinion.

D. An opinion as to whether the defendant presents a substantial danger to himself, herself, or others or presents a substantial risk to public safety or to property without a prescribed regimen of medical, psychiatric, or

psychological care or treatment.

7. The examiner shall not render an opinion or issue a report on the defendant's lack of criminal responsibility if the examiner believes that the defendant is not fit to proceed until this Court makes a determination as to the defendant's fitness.
8. If an examination cannot be conducted because of the unwillingness of the defendant to participate in the examination, the report shall so state and shall include, an opinion as to whether the unwillingness of the defendant is the result of mental disease or defect.
9. The examination shall be for a period not exceeding sixty (60) days or if applicable such longer period as the Director of DAABHS or his or her designee determines to be necessary for the purpose of the examination.
10. The examiner shall provide a copy of the report to DAABHS. DAABHS shall file a copy of the report with the Clerk of the Court.
11. The Clerk of the Court shall provide a copy of the report to defense counsel and the prosecuting attorney.

IT IS SO ORDERED.

_____ _____

Date Circuit Judge

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ **Client ID:** _____
Mailing Address: _____ **Date of Birth:** _____
_____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: OSAMH- FORENSICS DEPARTMENT
P.O. BOX 1437 SLOT S176 LITTLE ROCK, AR 72203-1437

PHONE 501-396-6302 FAX 501-686-9198 EMAIL: Forensics@dhs.arkansas.gov
(Recipient Name/Address/Phone/Fax/Email)

for the specific purpose(s): FORENSIC EVALUATION

Specific information to be disclosed: _____

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to you.

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____ _____ _____
(Signature of Client) *(Date)* *(Witness-If Required)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*