INVESTIGATIONS UNDER THE DOMESTIC VIOLENCE SURVIVORS JUSTICE ACT

A Best Practices Manual for Defense Attorneys

PREPARED AND DISTRIBUTED BY THE DVSJA STATEWIDE DEFENDER TASK FORCE

May 2023

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[1] NB: of the female-designated facilities in New York, currently only Bedford Hills Correctional Facility allows for legal video conferences via WebEx.

I. Purpose of this Best Practices Manual

This manual is intended to provide guidance for defense attorneys, social workers, and other advocates assisting domestic violence survivors who are seeking resentencing under the Domestic Violence Survivors Justice Act (DVSJA) pursuant to Criminal Procedure Law section 440.47.[2] It was developed by the DVSJA Statewide Defender Task Force, a statewide group of defense attorneys and advocates from across New York State that also includes representatives from the New York State Defenders Association and the NYS Office of Indigent Legal Services, that works towards successful implementation of the DVSJA.

This manual will help you think through:

- How should I approach the process of investigating a DVSJA resentencing motion?
- How can I work collaboratively with my clients in the process?
- How can I tackle strategic questions that arise along the way?

II. The DVSJA's Corroboration Requirement

At the motion-filing stage, the DVSJA imposes an initial burden to submit the statutorily required corroborating evidence in order to get a hearing. *See* C.P.L. § 440.47(2)(c). Specifically, the applicant must submit "at least two pieces of evidence corroborating the applicant's claim that he or she was, at the time of the offense, a victim of domestic violence subjected to substantial physical, sexual or psychological abuse inflicted by a member of the same family or household as the applicant." *Id.*[3]

[2] That section authorizes survivors whose offenses occurred before the DVSJA's effective date (August 12, 2019) to apply for resentencing if they meet the threshold eligibility criteria. For survivors whose offenses occurred *after* August 12, 2019, they may pursue a DVSJA sentencing at their *initial* sentencing under Penal Law § 60.12, but they may not pursue resentencing at a later date, as the law is currently written. While some of the same investigative strategies detailed here will also apply to P.L. § 60.12 proceedings, this manual is specifically focused on post-conviction resentencing advocacy under C.P.L. § 440.47.

[3] The term "member of the same family or household as the applicant" is defined in C.P.L. § 530.11. *See* C.P.L. § 440.47(2)(c). This definition is broad and includes a spouse, intimate partner, former intimate partner, and other family members, and can even include people acting in quasi-parental roles, such as administrators in a group foster home.

For the first piece of corroboration, the statute is very specific about the types of corroboration required:

> At least one piece of evidence must be either a court record, presentence report, social services record, hospital record, sworn statement from a witness to the domestic violence, law enforcement record, domestic incident report, or order of protection. C.P.L. § 440.47(2)(c).

The DVSJA is more permissive in terms of what kind of evidence can qualify as the second piece of corroboration, giving the following non-exhaustive list of examples:

> local and state department of corrections records, a showing based in part on documentation prepared at or near the time of the commission of the offense or the prosecution thereof tending to support the person's claim, or when there is verification of consultation with a licensed medical or mental health care provider, employee of a court acting within the scope of his or her employment, member of the clergy, attorney, social worker, or rape crisis counselor as defined in section forty-five hundred ten of the civil practice law and rules, or other advocate acting on behalf of an agency that assists victims of domestic violence for the purpose of assisting such person with domestic violence victim counseling or support. *Id*.

III. Why Conduct an Investigation for a DVSJA Resentencing Motion?

DVSJA cases require significant investigation. This is necessary not only to meet the threshold corroboration requirement, but also to adequately prepare for a potential hearing or negotiation with prosecutors. Counsel representing people seeking resentencing must err on the side of seeking all records that are possibly relevant, even if the requests do not always yield useful results.

A DVSJA investigation should be guided by your individual client's experience, based on client interviews, discussions with witnesses, friends, and family, as well as a review of the documents from the underlying criminal case, the appeal, and any other post-conviction litigation.

IV. Initial Questions to Frame Your Investigation

Below are some preliminary questions to ask yourself as you undertake an investigation and begin to formulate the theory of your case. Note that the framing of these questions is *not* ideal for interviewing your client, where the approach should be open-ended and reflect sensitivity to your client's traumatic experience (see resources on trauma-informed interviewing below in Section V, *Tips to Keep in Mind*).

What is the abuse my client experienced?

- Was it physical, sexual, and/or psychological? Did any psychological abuse arise to the level of coercive control?
- When did the abuse occur? Were there multiple time periods or chapters to the abuse? Can my client locate any specific points in time that can be used as benchmarks?
- Who caused the harm? Did it come from multiple sources?
- Did my client experience any abuse that they might not recognize or characterize as such?

What kind of corroborating evidence might exist?

- Did anyone witness the abuse first-hand, or observe the effects (whether physical or psychological)?
- Did my client talk to anyone about the abuse – either before or after the offense was committed? Is it OK with my client if I try to speak with that person?
- What documentation might exist that would tend to support my client's account of their own experience?

V. Tips to Keep in Mind

- DVSJA investigations take a substantial amount of time—from a few months to over a year before filing.
- Client collaboration and communication are imperative.
- Interviewing and listening to your client are the most important part of the investigation.

- Try to keep interview questions as open-ended as possible and see where the story takes you.
- Be mindful that your client's story may emerge in a non-linear fashion. Sometimes key details will only come out after several retellings over the course of a series of conversations. It is important to be sensitive to your client's individual circumstances, including mental health challenges, reluctance to trust legal advocates, lack of perception of their experiences as abusive, or feelings of shame or anger about what happened to them and/or the harm they caused.
- Trauma-informed interviewing is extremely important. Advocates who do not yet have training in trauma-informed practices should consult relevant resources before embarking on DVSJA representation.
    - For example, counsel can consult:
        - An Introductory Guide to Coercive Control for the DVSJA Attorney: Coercive Control Is Domestic Violence, by the DVSJA Statewide Defender Task Force (especially pp. 33-34 on interviewing).
        - National Center on Domestic Violence, Trauma & Mental Health's Trauma-Informed Legal Advocacy Project resources, including their guide on Representing DV Survivors Who are Experiencing Trauma and Other Mental Health Challenges. Another great resource is a publication of the National Defense Center for Criminalized Survivors (formerly known as the National Clearinghouse for the Defense of Battered Women), authored by Linda Barnard and Andrea Yacka-Bible, When Community-Based Advocates Testify as Experts: Understanding and Explaining Trauma and Its Effects.

- You must ensure client consent in the investigation process.
    - Your client must affirmatively agree to each part of the investigation before you move forward.

    - It is crucial to meet with your client – or at the very least speak with them on confidential legal calls – to explain the investigation process and to make sure they feel comfortable with the specific types of investigative steps you plan to undertake. Your client is your best resource!
    - If they do not feel comfortable with any part of the investigation, then it's important to give them time to process your suggested plan, to answer any questions they have, and ultimately to respect their decisions about whether or not to speak to witnesses or interact with record-keeping institutions.
- Even an "unsuccessful" investigation offers an opportunity for healing.
    - A determination not to file a resentencing application based on an inability to secure the corroboration required by the statute can still offer healing to the survivor you are working with, if done with care and respect.
    - A critical part of representing survivors under the DVSJA is simply listening and receiving information. Most people have been silenced or disbelieved during their initial prosecution and throughout incarceration, as well as during their earlier abuse history. Working with someone on a potential DVSJA resentencing application offers an antidote to this prior treatment, outcome notwithstanding.

VI. Types of Documentation to Pursue

Records you must request:

Documents from initial prosecution

- Court file (including complaint, indictment, motion papers, pre-sentence memoranda, Sentence & Commitment)
- Presentence Report (Dept. of Probation): explicitly accessible under the DVSJA[4]

[4] When the legislature enacted the DVSJA, it also amended C.P.L. § 390.50, the provision governing the confidentiality of, and access to, presentence reports. The amendment

- Transcripts
    - If trial, entire trial record
    - If plea, plea and sentence minutes, and any other relevant appearance dates
    - If charged with co-defendant(s), plea/sentence/trial minutes for co-defendant(s)
- Expert reports
- Any competency reports and/or examination notes pursuant to C.P.L. § 730
- Trial counsel's file, including attorney's notes

Record on appeal and post-conviction proceedings

- All the documents above, plus:
    - Appellate counsel's notes
    - Appellate briefs and post-conviction motions
    - Trial court and appellate decisions
    - Court of Appeals leave application, if any
    - Federal habeas filings and decision, if any
    - Supreme Court petition for a writ of certiorari, if any

Law enforcement records

- All records where your client is a victim, subject, or witness, with release signed by client
- Records for any other relevant parties
- Sources:
    - NYS Police
    - NYPD
    - County sheriffs/police departments outside NYC: call or check websites for rules regarding records requests – some by FOIL, some not.

specifically gives people seeking resentencing under C.P.L. § 440.47 the ability to access their own presentence report for use in a potential application. DVSJA resentencing applicants now need only request the presentence report from the court. Depending on local practice, the court may issue an order directing the Department of Probation to disclose the report to the applicant and counsel. Sample requests to the court and proposed orders are included in the Appendix.

- For example, Albany County accepts electronic FOIL requests; Niagara County, on the other hand, requires the FOIL form to be sent by mail.

Court records on other dockets/other courts

- Orders of protection – Family Court/Criminal Court
- Criminal history records of the abuser from DCJS and/or the Office of Court Administration
  - You can request a Criminal History Record Search (CHRS) through the Office of Court Administration[5]
- Charges against an abuser in a separate offense – where public, certificates of disposition and accusatory instruments
- Family Court records from divorce or child custody proceedings, including transcripts of relevant proceedings

Medical/hospital records

- Request with signed HIPAA release from client
- Note: you can often use the NYS generic HIPAA form (included in appendix), but many hospitals have their own facility-specific forms.

Mental health counseling/psychiatric records

- Pre-incarceration – community based-providers, treatment programs (with HIPAA release from client)
- Post-incarceration
  - County jail mental health records (with HIPAA release from client)
  - Office of Mental Health records from DOCCS (with OMH-specific HIPAA release)

Child welfare/Family Court records

- Local child welfare agency (call/visit website for individual agency procedures)
  - In NYC, contact the Administration for Children's Services
  - Outside NYC, contact the Office of Children and Family Services

[5] Note that a CHRS search does not necessarily yield complete results, because the search is based on name and date of birth, not on the person's NYSID number.

- Statewide Child Abuse Registry (FOIL process through Office of Children & Family Services)

School records (e.g., referrals from school counselors, Individualized Education Plans ("IEPs"), etc.).

- Each school or school district should release records with a general release from your client. You will need to go to the school district's website or contact them directly for record request procedures.

Domestic violence organizations/counselors/shelters

- You will need to contact individual organizations for their record request procedures.

DOCCS records

- General Records
  - Program/Work Assignment History
  - Educational Profile
  - Disciplinary History
  - Visitor Log
  - Certificates
  - Progress Reports
- Office of Mental Health (OMH) (NB: specific release form required – see below)
- DOCCS medical records may be relevant if they demonstrate any lasting impact of abuse
- Parole records (if person has had prior board appearance)
  - NYCRR § 8000.5

Affidavits from witnesses

- C.P.L. § 440.47(2)(c) lists "sworn statement from a witness to the domestic violence" as one of the acceptable types of corroboration under the first category.
- As you are interviewing people who may have seen or been aware of the abuse your client experienced, consider whether it makes sense to obtain an affidavit from them to submit with the DVSJA application.

- Remember that the person does not necessarily need to have directly witnessed physical abuse for their affidavit to satisfy the statutory requirement.[6]
- Whether to obtain an affidavit from a witness to include with a DVSJA application may depend on strategic considerations, including how an affidavit might affect the impact of their testimony at a hearing.

Support / Reentry / Mitigation

- Letters from family and loved ones
- Letters from professors in prison college programs (Hudson Link, Bard, Marymount, Medaille)
    - Transcripts of college work in prison
- Letters of Reasonable Assurance from community-based organizations

VII. Important Releases

See attached Appendix of templates for sample release and letter request templates.

- General Records Release (to be used with prior counsel, educational institutions, community-based organizations, to accompany FOIL requests, etc.)
- OCA HIPAA Release (DOH-approved)
- NYS Office of Mental Health HIPAA Release ("OMH-11C")
- NYC Health+Hospitals HIPAA Release (English)
- NYC Health+Hospitals HIPAA Release (Spanish)
- NYS Office of Children & Family Services Release
- NYC Administration of Children's Services Release
- NYC Child Protective Services Release

[6] *People v. Danielle Coles*, 202 A.D.3d 706 (2d Dept. 2022) is currently the only appellate court decision in the state to have addressed this issue (making it binding on trial courts statewide). In that case, the Second Department ruled that affidavits from family members qualified as corroboration where the affiants overheard behavior on phones with the applicant that corroborated her claims of coercive control.

VIII. Some Strategic Questions Related to DVJSA Investigations

Though not the focus of this best practices manual, advocates should keep the following in mind:

What do I need to corroborate?

The scope of the corroboration requirement is the subject of debate. Defense advocates often reading it to mean evidence tending to support the fact that substantial abuse occurred, while prosecutors sometimes argue that an applicant must also corroborate (1) that the abuser was a member of the same family or household and/or (2) a temporal nexus, i.e., that the abuse was "ongoing" at the time of the offense.

When do I have enough corroboration to file the motion?

Deciding how much supportive documentary evidence to include at the application stage is a strategic consideration that must be made on a case-by-case basis. On the one hand, the initial filing is an important opportunity to frame the narrative and set the tone for the litigation going forward, which can weigh in favor of including more corroborating evidence at this stage.

On the other hand, limited evidence about contested facts, or lack of access to information in the prosecution's control, may weigh in favor of simply meeting the statute's requirements and then seeking discovery once the application is filed in order to more fully inform the defense strategy.

IX. Discovery Obligations in a DVSJA Proceeding?

For the defense?

- Neither the DVSJA nor C.P.L. § 245 mandate that the defense provide discovery in a post-conviction DVSJA proceeding. In fact, the discovery reform statute contemplates "reciprocal discovery" obligations for the defense *only* in the context of a "trial or pre-trial hearing." *See* C.P.L. § 245.20(4).

For the prosecution?

- On the other hand, the prosecution may be under a continuing duty to disclose evidence and information that can mitigate

punishment. *See* C.P.L. §§ 245.20(1)(k)(vii) (duty to disclose mitigation evidence), 245.60 (continuing duty to disclose).

Nonetheless, a court might exercise its discretion to order discovery even without explicit statutory authority to do so, which could become the subject of litigation. The DVSJA and C.P.L. § 245 are both relatively new laws, and the full scope of discovery obligations has not yet been fully defined. This issue has already arisen in DVSJA cases around a client's mental health, particularly when experts become involved in the proceeding.

X. Questions?

For questions and technical assistance regarding DVSJA investigations, please feel free to contact any of the following:

- DVSJA Attorney Support Project – New York State Defenders Association
    - Stephanie Batcheller, Senior Staff Attorney
    - 518-465-3524 x 41 / SJBatcheller@nysda.org
    - https://www.nysda.org/page/DVSJA
- Statewide Appellate Support Center – NYS Office of Indigent Legal Services
    - Mandy Jaramillo, Senior Appellate Attorney
    - (518) 486-6602 / SASC@ils.ny.gov
- Survivors Justice Project – Brooklyn Law School
    - Kate Mogulescu: kate.mogulescu@brooklaw.edu

Appendix of Templates

Release Templates

General Records Release……..1
OCA HIPAA Release (DOH-approved) ……..….2
NYS Office of Mental Health HIPAA Release ("OMH-11C")……4
NYC Health+Hospitals HIPAA Release (English)…….….5
NYC Health+Hospitals HIPAA Release (Spanish)…….6
NYS Office of Children & Family Services Release……...7
NYC Administration of Children's Services Release……..9
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Record Request Templates

Legal Call Request Letter……11
Legal Video Conference Request Letter[1]……..12
Prison Records Request Letter……..13
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[1] NB: of the female-designated facilities in New York, currently only Bedford Hills Correctional Facility allows for legal video conferences via WebEx.

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____, _____,
(name) (date of birth)

hereby grant authorization to any public or private agency, institution, individual or corporation, including but not limited to any attorney, school, youth facility, physician's office, hospital, mental health center, addiction treatment center, family counseling center, department of probation or parole, department of vital statistics or records, jail, prison or other detention facility, bureau of investigation, or shelter, where I have been or am currently being educated, evaluated, treated, held, confined or who has ever been involved in providing me with legal or other services, to release to my attorneys, **[ATTORNEY NAME AND/OR ORGANIZATION]**, any and all records in your possession related to me.

In addition, I authorize any employee, personnel or contractor, including but not limited to, physician, attorney, psychologist, social worker, nurse, aide or other personnel active in or familiar with the services provided to me, to communicate orally or in writing to the above designated representative concerning my history, treatment, prognosis and/or other topics of which such personnel may have knowledge.

In authorizing this disclosure I explicitly waive any and all rights I may have to the confidential maintenance of these records, including any such rights that exist under local, state and federal statutory and/or constitutional law, rule or order, including those contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub.L. No. 104-191, 110 Stat.1936 (1996).

This authorization is valid until revoked by me in writing. You may accept a photocopy of this authorization.

_____ _____

[CLIENT NAME FOR SIGNATURE] DATE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use
of the HIPAA compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number Din #
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Office of Mental Health - Department of Corrections & Community Supervision

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____
INSERT START DATE INSERT EXPIRATION DATE OR EVENT

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

☐ Patient declined copy

_____ X _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH2557 and/or OMH 11 or 11A and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information or mental health clinical records. However, this form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of redisclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested_____ Treatment Dates from_____ to_____
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT REASON FOR RELEASE OF INFORMATION	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.** ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
☐ Legal Matter ☐ Individual's Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ On this date:_____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

NYCHHC HIPAA – Autorisation de communiquer des renseignements sur la santé

TOUTES LES CASES DOIVENT ÊTRE REMPLIES

NE PAS UTILISER LE PRÉSENT FORMULAIRE POUR OBTENIR DES AUTORISATIONS EN MATIÈRE DE RECHERCHE OU DE COMMERCIALISATION, DE RECOLTE DE FONDS OU DE RELATIONS PUBLIQUES

NOM ET ADRESSE DU PATIENT	DATE DE NAISSANCE	NUMÉRO DE SÉCURITÉ SOCIALE DU PATIENT (SSN)
	NUMÉRO DU DOSSIER MÉDICAL	NUMÉRO DE TÉLÉPHONE

NOM DE L'AGENT DES SERVICES DE SANTÉ DEVANT COMMUNIQUER DES RENSEIGNEMENTS	RENSEIGNEMENTS SPÉCIFIQUES À COMMUNIQUER : Renseignements demandés_____ Dates de traitement du_____ au _____
NOM ET ADRESSE DE LA PERSONNE OU DE L'ENTITÉ À LAQUELLE LES RENSEIGNEMENTS SERONT COMMUNIQUÉS	RENSEIGNEMENTS À COMMUNIQUER (si la case est cochée, vous autorisez la communication de ce type de renseignements). **Attention : nous ne pouvons traiter votre demande que si toutes les cases sont cochées.** ☐ Alcoolisme ou toxicomanie Renseignements sur les programmes ☐ Renseignements sur la santé mentale ☐ Renseignements sur le dépistage génétique ☐ Renseignements liés au VIH/SIDA
RAISON DE COMMUNIQUER LES RENSEIGNEMENTS ☐ Question juridique ☐ Demande individuelle ☐ Autres (veuillez spécifier) :_____	QUAND CETTE AUTORISATION EXPIRERA-T-ELLE ? (Veuillez cocher une case) ☐ Événement :_____ ☐ À cette date :_____

Je soussigné (ou mon représentant agréé) autorise l'utilisation ou la communication de mes renseignements médicaux ou de facturation tels que je les ai exposés sur le présent formulaire.

Je comprends que mes renseignements médicaux ou de facturation peuvent être communiqués à nouveau et ne plus être protégés par la réglementation fédérale sur la protection des renseignements privés sur la santé, au cas où le ou les destinataires mentionnés sur le présent formulaire ne seraient pas tenus par la loi de protéger les renseignements privés.

Je comprends que si mes dossiers médicaux ou de facturation contiennent des renseignements relatifs à l'**ALCOOLISME** ou à la **TOXICOMANIE**, au **DÉPISTAGE GÉNÉTIQUE**, à la **SANTÉ MENTALE** ou aux **RENSEIGNEMENTS CONFIDENTIELS SUR LE VIH/SIDA**, ces renseignements ne seront pas communiqués aux personnes que j'ai indiquées, à moins que je n'aie coché les cases correspondant auxdits renseignements figurant sur le présent formulaire.

Je comprends que si j'autorise l'utilisation ou la communication de renseignements relatifs au VIH/SIDA, il est interdit à ses destinataires d'utiliser ou de communiquer à nouveau lesdits renseignements relatifs au VIH/SIDA sans mon autorisation, à moins que ce soit permis par les lois fédérales ou de l'État. Je comprends également que j'ai le droit de demander une liste de personnes qui pourraient recevoir ou utiliser mes renseignements relatifs au VIH/SIDA sans mon autorisation. Si je fais l'objet d'une discrimination du fait de l'utilisation ou de la communication de renseignements relatifs au VIH/SIDA, je pourrai m'adresser au Centre pour les droits de l'homme de l'État de New York en appelant le 212.480.2493 ou à la Commission des droits de l'homme de la ville de New York en appelant le 212.306.7450. Ces organismes sont chargés de protéger mes droits.

Je comprends que j'ai le droit de refuser de signer la présente autorisation et que mes soins de santé, le paiement de mes soins de santé, ainsi que mes prestations de soins de santé ne seront pas affectés si je ne signe pas le présent formulaire. Je comprends également que si je refuse de signer la présente autorisation, NYCHHC ne sera pas en mesure de satisfaire à ma demande de communiquer mes renseignements médicaux et de facturation.

Je comprends que j'ai le droit de demander de vérifier ou de recevoir une copie des renseignements mentionnés sur le présent formulaire d'autorisation en remplissant un formulaire de demande d'accès (*Request for Access Form*). Je comprends également que j'ai le droit de recevoir une copie du présent formulaire après l'avoir signé.

Je comprends que si j'ai signé le présent formulaire d'autorisation d'utiliser ou de communiquer mes renseignements médicaux ou de facturation, j'ai le droit de me rétracter à tout moment, sauf si NYCHHC a déjà entrepris certaines démarches fondées sur mon autorisation ou si celle-ci a été obtenue comme condition préalable à l'obtention d'une couverture d'assurance.

Si vous voulez annuler la présente autorisation, veuillez vous adresser au bureau de la Direction des renseignements sur la santé (*Health Information Management*) qui traite cette demande.

J'ai lu le présent formulaire et j'ai obtenu une réponse à toutes mes questions. En signant ci-dessous, je reconnais avoir lu et accepté tout ce qui précède.

SIGNATURE DU PATIENT OU DE SON REPRÉSENTANT PERSONNEL	SI VOUS N'ÊTES PAS LE PATIENT, VEUILLEZ INDIQUER EN LETTRES MAJUSCULES LE NOM ET L'ADRESSE DE CONTACT DU REPRÉSENTANT PERSONNEL SIGNANT LE FORMULAIRE
DATE	DESCRIPTION DU MANDAT DU REPRÉSENTANT PERSONNEL D'AGIR AU NOM DU PATIENT

Si HHC a demandé la présente autorisation, le patient ou son représentant personnel doit recevoir une copie du présent formulaire après l'avoir signé.

(If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.)

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed	Comments

Authorization for Release and Disclosure of Confidential Records, including Mental Health Records, Alcohol and/or Drug Treatment Patient Records and Correctional Facility Records

I _____, do hereby authorize staff from

_____
[Name of substance abuse treatment facility, correctional facility or OCFS facility]

to provide information to:

_____
[Name and Address of Counsel]

I understand that information pertaining to my attendance and progress in alcohol and other drug treatment is protected by Federal Regulation 42 CFR, Part 2 "Confidentiality of Alcohol and Drug Abuse Patient Records", as well as the Health Insurance Portability and Accountability Act of 1996 (HIPPA@) 45 C.F.R. Pts. 160 & 164); and cannot be disclosed without my written consent unless otherwise provided for in law. I willingly and voluntarily authorize the above named agency to disclose information regarding my treatment history, current and previous substance abuse history, and current need for treatment to the staff of the agency listed above.

I understand that information pertaining to my mental health status, including diagnosis and treatment, is protected by NYS Mental Hygiene Law 33 and CPLR 4507-4508 and cannot be disclosed without my written authorization unless otherwise provided for in law. I willingly and voluntarily authorize that information pertaining to my participation in mental health treatment and other programs and services associated with my incarceration or residential treatment may be disclosed to the staff of the agency listed above.

I understand that the purpose and need to disclose the above information is to assist the agency named above in the development of a family service plan for me and my child(ren) and to monitor my progress in programs and services.

Please check below if you wish these additional authorizations to apply:

__ I authorize the above-named social services/foster care agency to share information regarding me and my child(ren) with the above-named treatment agency or correctional facility to assist in the development of my treatment plan. My consent for release of such information is limited to this purpose.

__ I authorize the above-named social services/foster care agency to share my treatment information to the _____Family Court for the purpose of informing the court of my progress and to explain if I am temporarily unavailable for other services.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that the recipients of this information may not re-disclose it except as provided for in this document or as authorized by law.

_____ __/___/__ _____
[Signature of Client] (DOB) (Date)

_____ _____
[Signature of Witness] (Date)

Revoked on _____ _____
(Date) (Signature of Client)

_____
(Signature of Witness)

NYC Administration for Children's Services -AUTHORIZATION FOR CPS RECORDS

I,_____, D.O.B. _____currently residing at _____ hereby authorize the New York City Administration for Children's Services to furnish all child protective service investigations to which I am entitled pursuant to N.Y. S. Social Services Law to _____ affiliated with _____(agency), on my behalf in accordance with the Child Protective Services Act of 1973.

The names and dates of birth of the children belonging to the individual listed on the first line of this form as well as previous addresses of this individual are necessary to conduct a thorough and accurate search of the CONNECTIONS and CAS databases. Please furnish this information below.

Names and birth dates of children:

Previous address starting with most recent:

_____

_____

_____

_____ _____

PRINT NAME **SIGNATURE**

STATE OF NEW YORK)
)SS:
COUNTY OF _____)

On this _____ day of _____ , 20_____, before me personally came _____, (individual) to me known and known to be the same person described in and who executed the within statement, and she/he duly acknowledged to me that she/he executed the same.

_____
Notary Public

COMPREHENSIVE AUTHORIZATION

To: Child Protective Services

Re: [redacted] **Date of Birth:** [redacted]

I hereby authorize you to release and produce my entire file to and to discuss all its contents with **Attorney [NAME]**

[COUNSEL CONTACT INFORMATION]

or **any** authorized representative from the **[NAME OF LAW OFFICE OR LEGAL ORGANIZATION]** including other attorneys, administrative assistants, and paralegals.

I specifically authorize the **[NAME OF LAW OFFICE OR LEGAL ORGANIZATION]** to receive, possess, copy and inspect any of the following records: notes from investigator, notes from interviews with me, any founded or unfounded incident reports, any photographs, or any other records or report in my file.

I am aware that the information and documents sought are privileged, but it is my intention to authorize and ask you to share them with the Criminal Justice Advocacy Clinic. It is my intention that this release be as broad and comprehensive as possible to permit my attorneys at the Criminal Justice Advocacy Clinic to better to represent me.

I further intend that a copy or facsimile transmission of this document will be as effective as an original.

Thank you for your prompt cooperation with the requests of the Criminal Justice Advocacy Clinic.

_____
DATE

_____
[COUNSEL NAME FOR SIGNATURE]

Legal Call Request Template - PUT ON LETTERHEAD

[DATE]

VIA E-MAIL: [FACILITY LEGAL CALLS EMAIL ADDRESS:
[FacilityName]LegalCallRequests@doccs.ny.gov]

[FACILITY NAME]
[ADDRESS]

Re: [CLIENT NAME], DIN [##-A-####]

Dear Guidance Department:

I represent [CLIENT NAME], DIN [##-A-####] in a post-conviction proceeding. I am writing to request a 60-minute legal call with my client.

I am available at the following dates/times:

- [PROVIDE TWO DATES AND TIMES]

Please let me know if you require any additional information to process my request. Thank you in advance for your assistance.

Sincerely,

[ATTORNEY NAME]
[CONTACT INFO]

Legal Video Conference Request Template - PUT ON LETTERHEAD
(NB: Of the female-designated facilities, only Bedford Hills Correctional Facility currently allows legal video conferences.)

[DATE]

VIA E-MAIL: [EMAIL OF FACILITY STAFF RESPONSIBLE FOR SCHEDULING LEGAL VIDEO CONFERENCES (check with facility)]

[FACILITY NAME]
[ADDRESS]

Re: [CLIENT NAME], DIN [##-A-####]

To Whom It May Concern:

I represent [CLIENT NAME], DIN [##-A-####] in a post-conviction proceeding. I am writing to request a legal video conference with my client.

I am available at the following dates/times:

- [PROVIDE TWO DATES AND TIMES]

Please let me know if you require any additional information to process my request. Thank you in advance for your assistance.

Sincerely,

[ATTORNEY NAME]
[CONTACT INFO]

[DATE]

[Facility Name and Address]
Attn: Inmate Records

Re: Records Request
[CLIENT NAME], DIN [##-X-####]

To Whom It May Concern:

I currently represent the above-referenced individual in post-conviction proceedings. Enclosed please find a release form signed by [CLIENT NAME] requesting that your facility release [HER/HIS/THEIR] institutional records to us. Please send a copy of these records, including:

1) All quarterly inmate progress reports (general evaluations and/or final evaluations, all inmate progress reports related to pay (requesting either a pay increase or pay decrease), and all other progress reports in the file;
2) Inmate program assignment history;
3) Certificates of achievement and/or certificates of completion;
4) Inmate disciplinary history, with corresponding misbehavior reports and disciplinary hearing dispositions;
5) If applicable, any records relating to immigration holds;
6) FPMS inmate security classification;
7) Reception/Classification analysis with intake interview;
8) Inmate listing of visitor registrants; AND
9) Unusual incident reports.

If you have any questions or concerns about this request, you may reach me at [CONTACT INFO]. If possible, invoices and records may be emailed to me at [EMAIL] or mailed to my attention at the address below. Thank you for your assistance.

Sincerely,

[ATTORNEY NAME]
[CONTACT INFO]

Pre-Sentence Investigation Report Request Template - PUT ON LETTERHEAD

[DATE]

Via Email: [EMAIL OF JUDGE OR COURT ATTORNEY]

[JUDGE NAME AND ADDRESS]

Re: [CLIENT NAME + Docket/Indictment Number]

Your Honor:

I represent [CLIENT] in relation to [her/his/their] application for resentencing pursuant to C.P.L. § 440.47. The Court granted [CLIENT] permission to apply for resentencing and assigned counsel on [DATE OF ASSIGNMENT].

I am now writing to request a copy of the pre-sentence investigation report from [CLIENT'S] prosecution under [DOCKET/INDICTMENT NO. XX-XXXX]. Pursuant to C.P.L. § 390.50(2)(a), individuals seeking resentencing under C.P.L. § 440.47 are entitled to a copy of their presentence report upon written request. Attached is a release signed by [CLIENT] authorizing the disclosure of this record to us.

If you have any questions or concerns about this request, you may reach me at [CONTACT INFO]. If possible, the presentence report may be emailed to me at [EMAIL ADDRESS] or mailed to [MAILING ADDRESS].

Thank you in advance.

Sincerely,

_____

[COUNSEL NAME AND CONTACT INFO]

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Child Protective Services Records Request Template - PUT ON LETTERHEAD

[Date]

[For requests to the NYC Administration of Child Services (ACS), requests can be emailed to ACSRecordRequests@acs.nyc.gov]
[COUNTY NAME] Department of Social Services
Child Protective Services
[ADDRESS]

To Whom It May Concern:

I am [NAME AND ORGANIZATION], and I am writing with a records request on behalf of our client, [CLIENT]. Specifically, I am requesting any and all documents, including complaints and investigations, and records pertaining to [CLIENT] and/or any of her [#] children, [NAMES] (see DOB information below) when any of them were the victim, witness, or subject at issue in a complaint or investigation.

- [names of client and/or children, and DOB's]

The records requested are necessary for the legal representation of [CLIENT]. Attached please find a release of information signed by [CLIENT] requesting and consenting to the release of these records.

If you have any questions about this request, please contact me at [CONTACT INFO]. Thank you in advance for your assistance.

Sincerely,

_____
[ATTORNEY NAME]
[CONTACT INFO]

COUNTY COURT OF THE STATE OF NEW YORK,
COUNTY OF _____

X

THE PEOPLE OF THE STATE OF NEW YORK ORDER

- against Ind. No. _____
Index No. _____

_____,

Defendant/Movant.
---------- X

It is hereby ordered that, pursuant to C.P.L. § 390.50(2)(a), the _____ County Department of Probation shall provide a copy of defendant's presentence report, with any and all attachments, to defendant and defendant's counsel, _____, for use in an application for resentencing pursuant to C.P.L. § 440.47.

ENTERED:

_____

Dated: _____

Hon. _____
_____ County Court