

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Connecticut Valley Hospital
Conditional Release Application Community Provider Approval Form

I have received and reviewed the *Psychiatric Security Review Board (PSRB) Acquittee Information Packet* for _____ and the enclosed Application for Conditional Release. [Acquittee's Name]

For the purposes of this Conditional Release, this agency/private practitioner agrees to provide the following services:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

This agency/private practitioner agrees to immediately notify the PSRB—as ordered by the PSRB and as required by Connecticut General Statutes Section 17a-580, et seq.—should the acquittee be non-compliant with any aspect of the Conditional Release described in this application.

Signature of Agency Director/Private Practitioner

Date

Printed Name of Agency Director/Private Practitioner

Agency Name