NOTICE OF COMMITMENT CHANGE

STATE OF NORTH CAROLINA

Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Facility Name:	
Facility Address:	Film #: (Physical location)
IN THE MATTER OF:	Respondent's Name:
	Client Record Number:
	Unit/Building/Ward (When Applicable):
TO: Clerk of Superior C	court, County
This is to certify that the	commitment status of the above-named respondent has changed due to the following:
The respondent is no	longer in need of inpatient hospitalization and is unconditionally discharged on(date).
The respondent no lo	nger meets the criteria for \Box outpatient \Box substance abuse commitment and is discharged on
	(Date) longer in need of inpatient treatment and is conditionally released on(date) to be al discharge on(date).
Conditions of release ar	e:
	escaped D breached conditions of release on(date); and is discharged from(date).
The respondent or leg	gally responsible person signed a consent for voluntary treatment on(date).
	admitted as a voluntary minor and has turned 18 years of age. The respondent signed a consent for (date).
The respondent was Therefore, outpatient co	admitted to a 24-hour facility on an involuntary basis on (date). mmitment is terminated.
The respondent has r (date).	noved to another state or location of respondent is unknown so commitment is terminated on
committed by t	longer in need of inpatient treatment. The respondent is released from inpatient commitment and is he court to outpatient treatment for days on(date). The respondent was m the 24-hour facility on(date).
The respondent is on inpatient hospit	a split commitment and is no longer in need of inpatient treatment. The respondent is released from talization and is committed to outpatient treatment for days on (date).
	transferred to in County on
(date).	
	ed on (date).
Uther (Specify):	
Signature/Title	Date
	tatus is Inpatient Commitment, signature must be that of Attending Physician. tatus is Outpatient or Substance Abuse Commitment, signature must be that of Responsible Professional.
Copy: Clerk of Superior	Court where petition initiated (date). (Specify:) Court where facility located(date). Court where outpatient or substance abuse commitment supervised (date).
(opeony	Medical Record Respondent and State's Attorney (date). Designated outpatient treatment center or physician (Date).(Specify)
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