*****THIS RELEASE ONLY AUTHORIZES THE DISCLOSURE OF THIS INFORMATION TO THE FEDERAL PUBLIC DEFENDERS. NO OTHER AGENCY, INDIVIDUAL, OR MEDIA OUTLET MAY BE ADVISED OF THIS REQUEST*****

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Date of Birth: _____
Social Security Number: _____

I hereby authorize _____ to release and disclose my protected medical and/or mental health/psychotherapy information pertaining to me to the **Federal Public Defender's Office, 301 N. Main, Suite 850, Wichita, Kansas, 67202, (316) 269-6445**. Specifically, I am authorizing_____ to release the following information:

Any and all medical/mental health information of patient including: admission and discharge summaries, psychological and psychiatric evaluation reports, substance abuse evaluation reports, medical history, lab reports, diagnosis, treatment plan, summary of treatment, progress notes and reports to include consultation reports and medications from: to present.

I further authorize any agent or officer from _____ to discuss with a representative of the **Federal Public Defender's Office, 301 N. Main, Suite 850, Wichita, Kansas, 67202, (316) 269-6445** information contained within my protected health information.

I understand:

- The information authorized for release and disclosure may be protected by federal and/or state law including psychiatric or mental health records, information which may be considered a communicable, or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

- I may cancel this authorization at any time by sending written cancellation to the facility/provider that released my protected health information and will have no effect on actions taken in reliance upon this form prior to my written cancellation.

- This Authorization expires 1 year from the date signed.

- I am also authorizing the Federal Public Defender's Office to re-disclose any information it may receive to an interested third party. I authorize the Federal Public Defender's Office to use its professional discretion in deciding who should receive this information.

- I understand that this authorization is voluntary. My treatment, payment for my health care, enrollment or eligibility for benefits will not be effected if I do not sign this form.

A photocopy of this form will have the same force and effect as the original.

_____

Signature **Date**