

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below.)

I authorize _____ to release the information described below,
contained in the medical record of: _____,
Date of Birth _____.

Please release this information to:

I request and authorize the above-mentioned doctor or health care provider to release the information specified below to, and speak freely with the Federal Public Defender, or any agent thereof. I understand that the information to be released includes information regarding:

- () Drug Abuse or Alcohol Abuse, if any () Psychological or Psychiatric Conditions, if any, including psychotherapy notes
() Other Medical Records () Sickle Cell Anemia, if any
() HIV/AIDS Status
-

Information Requested:

- | | |
|---|--|
| () Medical History/Physical Examination
() Physician's Complete Office Chart
() Clinical, Laboratory and/or ETC Reports
() Progress Notes
() All Correspondence and Reports
() E.R. and Outpatient Records
() Physical Therapy
() Psychiatric History
() Psychological Testing | () Treatment Plan
() Consultations
() Educational Information
() Case Conferences
() Interim Summary
() Occupational Therapy
() Discharge Summary
() Entire Record
() Other _____ |
|---|--|

Dates Covered: () All admissions of care at the facility or by this doctor
 () Limited to treatment dates and for conditions described as follows: _____

Purpose: I understand that this information will be used for:

- () Purposes of further evaluation and treatment
() At my request
(X) Other: LEGAL REQUEST

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has already been taken to comply with it. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations. Photocopies of this release are to be given the same effect as the original.

This authorization ends: () on (date) _____
 () when the following event occurs _____

My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study, or to receive health care when the purpose is to create health information for a third party.

Date

Patient or legally authorized individual signature