OFFICE OF THE STATE PUBLIC DEFENDER

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Name (please print)		Date of Birth
I authorize		
☐ to disclose and give copies to the Office of the State Public Defender, the following information now in your possession or control and to answer any questions that may be asked regarding this information.		
This authorization covers the approximate time period	From	To
	☐ Any and All treatment	
Medical treatment record(s) requested		
☐ Entire Record ☐ history and physical ☐ admission/intake form ☐ pharmacy records ☐ treatment/progress notes	☐ laboratory reports/studies ☐ radiographs/MRI's/imaging studies ☐ physician's orders ☐ nursing notes	☐ medication sheets ☐ discharge summary/orders ☐ HIV/AIDS diagnosis/treatment records ☐ other
Mental health treatment record(s) requested		
☐ Entire Record ☐ history & physical ☐ education assessment ☐ psychological testing	☐ diagnosis/assessment ☐ progress/treatment notes ☐ observation report ☐ competency/sanity evaluations	☐ physicians orders ☐ medication sheets ☐ discharge summary/orders ☐ other
Drug and alcohol treatment information requested		
☐ Entire Record ☐ substance abuse evaluation	☐ discharge summary/orders ☐ progress/treatment notes	☐ diagnosis or testing instrument ☐ other
☐ other records Specify: (e.g. SSA, DPHHS, billing/payment, vocational)		
The purpose of this disclosure is: *legal purposes*	This consent expires: *one year from the date of signing*	

I understand that:

- The requested information may not be protected from re-disclosure by the Office of the State Public Defender; However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (42 C.F.R., part 2), the Office of the State Public Defender may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.
- I may refuse to sign this authorization and that my refusal will not result in the termination of my representation or ability to obtain treatment, services, or affect my eligibility for benefits.
- I may have a copy of this authorization
- A photocopy/fax of this release is valid and may be used in lieu of the original.
- I may revoke this authorization in writing at any time.

I have read this authorization and by signing acknowledge that I knowingly and freely consent to the disclosure of this information.

Signature (or signature of person authorized to sign)	Date of Signing

The authorized person signing above is the:	☐ parent	☐ legal guardian	☐ other

I no longer wish to share the information indicated above with the Office of the State Public Defender and hereby revoke this authorization.

Signature Date