UNITED STATES PROBATION SYSTEM AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION DRUG ABUSE PROGRAMS

| 1, | | the undersigned, |
|--|--|---|
| | (Name of Client) | |
| hereby authorize | | to release confidential |
| information in its records, possession, o | (Name of Program) or knowledge, of what | tever nature may now exist or come to exist to the United |
| States Probation Office of the | | District of . |
| | (Name of Court) | District of (State) |
| urine testing results; type, frequency an to program rules; type and dosage of medate of and reason for withdrawal from The information which I now a | ad effectiveness of ther edication; response to program; and prognos authorize for release is | ude: date of entrance to program; attendance records; crapy (including psychotherapy notes); general adjustment of treatment; test results (psychological, vocational, etc.); asis. It to be used in connection with my participation in the off my |
| (pretrial release, post-trial release, prob | | |
| official duties, including total or partial Commission when necessary for the pu I understand that this authorizate use or disclose this information expire | disclosure of such, to prose of discharging in tion is valid until my res. I understand that | formation hereby obtained only in connection with its of the District Court and/or United States Parole its supervisory duties over me. release from supervision, at which time this authorization information used or disclosed pursuant to this longer be protected by federal or state law. |
| I understand that I have the right notification to the program's privacy co | | orization, in writing, at any time by sending such written |
| | (Name and Address | ss of Program) |
| authorization to further disclosure of su satisfy the condition of my supervision | ich information. I also that requires me to pa | ease confidential information, I will thereby revoke my o understand that revoking this authorization before I articipate in the program will be reported to the court. uld be considered a violation of a condition of my post- |
| (Signature of Parent or Guardian if Client | t is a Minor) | (Signature of Client) |
| | • | . 5 |
| (Date Signed) | | (Date Signed) |
| | | |
| (Name & Title of Witness) | | (Date Signed) |

UNITED STATES PROBATION SYSTEM AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PROGRAMS

| 1, | , the undersigned, |
|---|---|
| (Name of Client) | |
| hereby authorize | to release confidential |
| (Name of Program) | |
| information in its records, possession, or knowledge of what | ever nature may now exist or come to exist to the United |
| States Probation Office of the(Name of Court) | District of . |
| (Name of Court) | (State) |
| The confidential information to be released will including testing results; type, frequency and effectiveness of the to program rules; type and dosage of medication; response to psychotherapy notes; date of and reason for withdrawal from | o treatment; test results (psychological, vocational, etc.); |
| The information which I now authorize for release is ordered report. | s to be used in connection with the preparation of a court- |
| I understand that the probation office may use the in official duties, including total or partial disclosure of such, to | formation hereby obtained only in connection with its o the District Court. |
| this authorization to use or disclose this information expires. to this authorization may be disclosed by the recipient and m | |
| notification to the program's privacy contact at: | |
| (Name and Addres | ss of Program) |
| I understand that if I revoke this authorization to releauthorization to further disclosure of such information. I als completion of the presentence investigation will be reported | |
| (Signature of Parent or Guardian if Client is a Minor) | (Signature of Client) |
| | |
| (Date Signed) | (Date Signed) |
| | |
| (Name & Title of Witness) | (Date Signed) |

UNITED STATES PROBATION SYSTEM AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION MENTAL HEALTH TREATMENT PROGRAMS

| I, | , the undersigned, | | | |
|---|---|--|--|--|
| (Name of Clien | t) | | | |
| hereby authorize | to release confidential | | | |
| (Name of Prog | | | | |
| information in its possession to the United States Probation | | | | |
| | (Name of Court) | | | |
| The confidential information to be released will incording detection test results; type, frequency, and effectiveness adjustment to program rules; type and dosage of medication psycho-physiological measurements, vocational, sex offensor reason for withdrawal or termination from program; diagnost | r; response to treatment; test results (e.g., psychological, e specific evaluations, clinical polygraphs); date of and | | | |
| This information is to be used in connection with m has been made a condition of my post-conviction supervision supervised release, or conditional release), and may be used probation officer informed concerning compliance with any understand that this authorization is valid until my release for disclose this information expires. I understand that information be disclosed by the recipient and may no longer be protected. | by the probation officer for the purpose of keeping the condition or special condition of my supervision. I rom supervision, at which time this authorization to use or tion used or disclosed pursuant to this authorization may | | | |
| I understand that I have the right to revoke this auth notification to the program's privacy contact at: | norization, in writing, at any time by sending such written | | | |
| (Name and Addre | ess of Program) | | | |
| I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision. | | | | |
| (Signature of Parent or Guardian if Client is a Minor) | (Signature of Client) | | | |
| (Date Signed) | (Date Signed) | | | |
| (Date Signed) | (Date Signed) | | | |
| (Name & Title of Witness) | (Date Signed) | | | |

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

(DRUG OR ALCOHOL ABUSE PROGRAMS)

| I, | | , the undersigned, |
|--|---|--|
| (Name of | Client) | |
| hereby authorize | | to release confidential |
| | f Program) | |
| information in its records, possession, or knowledge, o | f whatever nature may now exist or o | come to exist to the United |
| States Pretrial Services or Probation Office for the | District of | |
| | (Name of Court) District of | (State) |
| The confidential information to be released wi urine testing results; type, frequency and effectiveness to program rules; type and dosage of medication; respondate of and reason for withdrawal from program; and put the information which I now authorize for releasorementioned program which has been made a conditional control of the con | of therapy (including psychotherapy onse to treatment; test results (psychotrognosis. ease is to be used in connection with tion of my pretrial release. | notes); general adjustment logical, vocational, etc.); my participation in the |
| I understand that this authorization is valid unt to use or disclose this information expires. I understan authorization may be disclosed by the recipient and ma | d that information used or disclosed | pursuant to this |
| I understand that I have the right to revoke this notification to the program's privacy contact at: | s authorization, in writing, at any time | e by sending such written |
| (Name and | Address of Program) | |
| I understand that if I revoke this authorization authorization to further disclosure of such information satisfy the condition of my supervision that requires m My revocation of authorization under such circumstant supervision. | I also understand that revoking this e to participate in the program will be | s authorization before I e reported to the court. |
| (Signature of Parent or Guardian, if Client is a Minor) | (Signatur | re of Client) |
| (Date Signed) | (Date | Signed) |
| (Name & Title of Witness) | (Date | Signed) |

UNITED STATES PRETRIAL SERVICES SYSTEM AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION MENTAL HEALTH TREATMENT PROGRAMS

| Ι, | , the undersigned, |
|--|---|
| (Name of C | Client) |
| hereby authorize(Name of Pro | ogram) to release confidential |
| information in its possession to the United States Pretria | 1 Services Office in the |
| information in its possession to the efficient states Fred in | (Name of Court) |
| drug detection test results; type, frequency, and effective and dosage of medication; response to treatment; test results; | l include: date of entrance to program; attendance records; veness of therapy; general adjustment to program rules; type alts (e.g., psychological, psycho-physiological measurements, and reason for withdrawal or termination from program; |
| has been made a condition of my pretrial supervision, are of keeping the pretrial services officer informed concern supervision. I understand that this authorization is vauthorization to use or disclose this information expires this authorization may be disclosed by the recipient an information may also be made available to the probation accordance with federal law. | ith my participation in the above-mentioned program, which and may be used by the pretrial services officer for the purpose ing compliance with any condition or special condition of my alid until my release from supervision, at which time this . I understand that information used or disclosed pursuant to d may no longer be protected by federal or state law. Such on office for the purpose of preparing a presentence report in |
| I understand that I have the right to revoke this notification to the program's privacy contact at: | authorization, in writing, at any time by sending such written |
| (Name and Ac | ddress of Program) |
| authorization to further disclosure of such information. satisfy the condition of my supervision that requires me | to release confidential information, I will thereby revoke my I also understand that revoking this authorization before I to participate in the program will be reported to the court. See could be considered a violation of a condition of my |
| (Signature of Parent or Guardian if Client is a Minor) | (Signature of Client) |
| | |
| (Date Signed) | (Date Signed) |
| | |
| (Name & Title of Witness) | (Date Signed) |