RELEASE OF INFORMATION

I, [**Client Name**], authorize and permit **[Lawyer]** and his/her approved representative (e.g. attorney, investigator, social worker) to inspect and/or copy any and all documents and records pertaining to me which are in the custody or control of the DC Department of Corrections, the U.S. Bureau of Prisons, federal, state, or other prisons or jails, Department of Youth Rehabilitation Services**,** in which I am or have been held, the U.S. Parole Commission, DC Board of Parole, the U.S. Probation Office, Court Services and Offender Supervision Agency, Child and Family Services Agency, or Court Social Services**.** I further authorize release of my complete medical, mental health, educational, employment, and other institutional records including, but not limited to, any records of psychiatric examination, treatment for drug and/or alcohol abuse, or HIV/AIDS treatment. This release also permits my representative(s) to interview persons at the above listed agencies.

For medical records: by signing this form, I authorize the use and disclosure of my protected health information from _____, to the above named for the purpose of legal representation before Superior Court of the District of Columbia or the United States Parole Commission, pursuant to my rights below and the HIPAA Standards of April 14, 2003 (see 45 CFR 164.508(c)(2)). I authorize disclosure of (check one) [ ] all information; or [ ] only records relating to: _____.

A photocopy of this release is intended to have the same force and effect as the original.

- I understand that I may revoke this authorization at any time, and must do so in writing.
- I understand that this authorization terminates automatically at the end of PDS's representation.
- I understand that information disclosed based on this authorization may be re-disclosed by the entity or the person who receives the information. Once disclosed, it is possible that the information will not be protected under federal medical privacy law.
- I understand that I may inspect or copy the protected health information to be used or disclosed.
- Any health care provider and its employees who release records within the parameters indicated above are released from legal liability.
- The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act. Disclosures may only be made pursuant to valid authorization by the client or as provided in Title III or IV of the Act. The Act provides for civil damages and criminal penalties for violations (D.C. Code § 6-2004 (1995)).
- If the records or information being released involve treatment for alcohol or substance addition, federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records" also protect the records (42 C.F.R. Part 2, 42 U.S.C. § 290dd-2).
- If the records or information released involve treatment for alcohol or substance addition, this information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.

_____	_____	_____-__-_____	_____
Signed	Date	Soc. Sec. #	Date of Birth

This authorization expires automatically one year from the date sign