

**FLORIDA DEPARTMENT OF CORRECTIONS
 CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE INSPECTION AND RELEASE
 OF CONFIDENTIAL INFORMATION**

I, _____, authorize _____
(Name, organization or general designation of program making disclosure)
 to disclose to RECORDS DEPOSITION SERVICE, INC. PO BOX 5054, SOUTHFIELD, MI 48086-5054 T: 248-357-3330 F: 248-357-3337
(Name of person(s) or organization(s) to which disclosure is to be made)
 Purpose of disclosure authorized herein: FOR DISCOVERY BEFORE TRIAL

The undersigned hereby authorizes the inspection and release of copies of my medical records indicated below by the above-named health care facility/medical record custodian only to the above-named entity(ies) or persons or their agents. Indicate all of the records authorized to be inspected/released by **initialing** in the appropriate box(es) below:

INITIAL BELOW FOR RELEASE OF INFORMATION	
	A. Release of all medical records <u>except</u> : any information relating to HIV testing, AIDS and AIDS-related syndromes; psychiatric and psychological information; or alcohol and substance abuse treatment information related to my condition, care, and confinement (initial box).
	B. Release of any records regarding HIV testing, AIDS and AIDS-related syndromes relating to my condition, care, and confinement (initial box).
	C. Release of any records of psychiatric and psychological information (mental health records) other than psychotherapy notes relating to my conditions, care, and confinement (initial box).
	D. Release of all dental records relating to my condition, care and confinement (initial box).
	E. Release of any records regarding alcohol and substance abuse treatment relating to my condition, care, and confinement. I understand that my records are protected under the federal regulations governing <i>Confidentiality of Alcohol and Drug Abuse Patient Records</i> , 42 U.S.C. §290 (ee)(2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. As to release of alcohol/substance abuse treatment records, please state the specific information to be released as provided by 42 U.S.C. §290 (ee)(2), Fed rule 42 CFR Part 2 (initial box):

Name of information -- dates of treatment/programs, etc., if possible

NOTE: IF PSYCHOTHERAPY OR SUBSTANCE ABUSE PROGRESS NOTES ARE THE SUBJECT OF THE RELEASE, OTHER RECORDS CANNOT BE THE SUBJECT OF THE SAME AUTHORIZATION. RELEASE OF PSYCHOTHERAPY OR SUBSTANCE ABUSE PROGRESS NOTES IN ADDITION TO THE RECORDS SPECIFIED ABOVE WILL REQUIRE A SEPARATE AUTHORIZATION (SEE BELOW).

I understand that I may revoke this consent and authorization at any time, provided the revocation is in writing, except to the extent that action has been taken in reliance on it, and that in any event, this consent and authorization shall be effective for 90 days unless I specify a different expiration as follows: _____
(Specification of the date, event, or condition upon which this consent expires if less than six months or greater than 90 days)

In furtherance of this authorization, I (we) do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized. I acknowledge the extent of my authorization of release as to the records and information denoted in paragraphs A, B, C, D and E by **initialing** the appropriate box(es) above.

 SIGNATURE OF PATIENT (Guardian or Statutorily Authorized Representative, when required)

 Date

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY OR SUBSTANCE ABUSE PROGRESS NOTES

I, _____, authorize _____
(Name, organization or general designation of program making disclosure)

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to disclose to RECORDS DEPOSITION SERVICE, INC. PO BOX 5054, SOUTHFIELD, MI 48086-5054 T: 248-357-3330 F: 248-357-3337
 (Name of person(s) or organization(s) to which disclosure is to be made)

Purpose of disclosure authorized herein: FOR DISCOVERY BEFORE TRIAL

The undersigned hereby authorizes the inspection and release of copies of my psychotherapy progress notes and/or my substance abuse progress notes as indicated below by the above-named health care facility/medical record custodian only to the above-named entity(ies) or persons or their agents. Indicate all of the records authorized to be inspected/released by **initialing** in the appropriate box(es) below:

INITIAL BELOW FOR RELEASE OF INFORMATION

- A. Release psychotherapy progress notes (initial box):
- B. Release substance abuse progress notes (initial box):

Name of information -- dates of treatment/programs, etc., if possible

I understand that I may revoke this consent and authorization at any time, provided the revocation is in writing, except to the extent that action has been taken in reliance on it, and that in any event, this consent and authorization shall be effective for 90 days unless I specify a different expiration as follows: _____
 (Specification of the date, event, or condition upon which this consent expires if less than six months or greater than 90 days)

In furtherance of this authorization, I (we) do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized. I acknowledge the extent of my authorization of release as to the records and information denoted in paragraphs A and B **initialing** the appropriate box(es) above.

 SIGNATURE OF PATIENT (or Next of Kin, Guardian or Authorized Representative, when required) Date

COMPLETE NOTARY PORTION ONLY WHEN REQUEST IS NOT FROM CURRENT INMATE/OFFENDER PERSONALLY KNOWN TO WITNESS OR IS FROM SOURCE EXTERNAL TO DEPARTMENT

STATE OF _____
 COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this day of _____, 20____,
 by _____ who is personally known to me or who has produced
 _____ as identification.

 Notary Public Signature
 Print, type, or stamp commissioned name of Notary Public
 My Commission Expires: _____

SEAL

ACKNOWLEDGEMENT OF RECEIPT OF COPY OF SIGNED AUTHORIZATION(S)

Inmate/Offender Name _____
 DC# _____
 R/S _____
 Date of Birth _____
 SS# _____
 Institution/Office _____

Witness Name _____
 Witness Signature _____
 Date: _____