INFORMATION MAY BE DISCLOSED BY:

Law Office of the Public Defender
17th Judicial Circuit
201 SE 6th Street, 3872
Fort Lauderdale, Florida 33301
(954)831-8650

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____

Address: _____

Phone #: _____

METHOD OF DISCLOSURE:

_____ Pick up at Law Office of the Public Defender, 201 SE 6th Street, 3872, Fort Lauderdale, Florida 33301

_____ Mail to the following Address:

Name: _____

_____

_____

_____ Fax #: To: _____

Fax Number: _____

_____ Email Address: (please note that emailing may not be a secure method of communication): _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ Client file (excluding medical information)

_____ Client file (including medical Information). (Include information selected):

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results _____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations _____ Diagnostic Test Reports (Specify Type of test(s)

_____

_____ Other: (specify) _____

I specifically authorize the release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider
____ Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes

_____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

_____ Personal Use

_____ Legal representation

_____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. **I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.**

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations, attorney client privileges and work product privilege. By making this request, I hereby understand that the Law Office of the Public Defender cannot limit nor prevent disclosure of the information contained herein by the person receiving this information.

CONDITIONING: I understand that completing this authorization form is voluntary.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the Law Office of the Public Defender, General Counsel, 201 SE 6th Street, 3872, Fort Lauderdale, Florida 33301. I understand that the revocation will not apply to information that has already been released in response to this authorization.

IF I DO NOT READ AND UNDERSTAND ENGLISH, THIS AGREEMENT HAS BEEN READ TO ME IN THE _____ LANGUAGE BY _____ AND I UNDERSTAND AND AGREE WITH ITS ENTIRE CONTENTS.

Client/Legal Representative

_____ Date: _____
Signature
Inmate ID (if applicable) _____
Detention Facility: _____
DOB # _____

STATE OF FLORIDA

COUNTY OF _____)

On this _____ date of _____, 20 __ personally appeared _____ who is known to me or produced _____ as identification.

SEAL

_____
Notary Name:
Expiration Date: