Law Office of the Public Defender

201 SE 6TH Street, Suite 3872 | Third Floor, North Wing

Fort Lauderdale, FL 33301

AUTHORIZATION TO RELEASE CLIENT FILE

Date: _____/_____/20_____

THE CLIENT INFOMATION BEING REQUESTED FROM THE LAW OFFICE OF THE PUBLIC DEFENDER IS THE FOLLOWING:

Client's name: _____

Date of Birth: ____/_____/_____

Gender: _____

Case number(s) for this request:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Initial ( )

AUTHORIZATION TO RELEASE CLIENT FILE

The Law Office of the Public Defender can only accept an original document. **This form may only be notarized by an employee of the Law Office of the Public Defender if the client is out of custody and physically present at the time of notarization.** This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards.

Date: _____, 20___

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: (Must be addressed to a specific name)

To (Person): _____

Facility/Firm: _____

Address: _____

Phone #: _____

Initial ( )

METHOD OF DISCLOSURE: (Please initial)

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

_____ Pick up by Authorized Designee, (must provide ID):

_____

_____ Mail to the following Address:

Attention (Name): _____

_____

_____

_____ Fax #: To: _____

Fax Number: _____

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

_____

_____ CIP portal to Email Address: _____

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

Initial ( )

_____ 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.

Initial ( )

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

Signed by:

_____Client or

_____Legal Representative (documentation must be attached for legal representation).

_____ 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:

Notary Phone number:

Notary Email:

Notary Address:

Initial ( )