AUTHORIZATION FOR RELEASE OF INFORMATION

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 44 C.F.R. 164.508(c).

I, _____d/o/b/_____ , hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I hereby authorize (person/organization providing the information):

_____

to release specified information in my client record to my attorney, Lisa Miles, Miles & Montgomery, Attorneys, and her agents for the purpose of the preparation of my defense in a pending criminal matter before the Court in_____County, North Carolina. This information shall include, but not be limited to, the following:

[] reason for referral
[] psychiatric, psychological, social medical information affecting current functioning
[] current medications
[] discharge summary
[] employment records
[] history of psychotropic drugs prescribed
[] medical history and diagnosis
[] school academic achievement and behavior
[] diagnosis
[] prognosis
[] human immunodeficiency virus (HIV) history and treatment
[] Acquired human immunodeficiency syndrome (AIDS) history and treatment
[] history of substance abuse, use and/or treatment*

* I hereby waive protection of my records under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The waiver of my consent has been explained to me and I understand that I am hereby consenting to the release of said records to my attorney. This consent shall be valid for one year or until such time as I revoke this consent, except to the extent that action has been taken in reliance on it.

[] other information necessary to the preparation of my defense:_____

_____

This information shall include all records maintained by the above-named individual or organization, regardless of date of referral, treatment, discharge or other date.

I. I understand that this authorization will expire on _____.
Client Initials: _____

II. I understand that I may revoke this authorization at any time by notifying the providing organization or individual in writing, but if I do so it will not have any effect on any actions taken before the revocation was received.
Client Initials: _____

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled.

This _____ day of _____ 200___.

_____d/o/b/_____ _____
Signature of Client Witness