CONSENT INSPECTION AND/OR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize _____ **County Jail** to disclose to _____**,** purpose of disclosure authorized herein: legal/court purposes in criminal case the undersigned hereby authorizes the inspection and release of the copies of my medical records indicated below by the above-named health care facility/medical record custodian only to the above named company or persons or the agents. Indicate all the records authorized to be inspected/released by initialing in the appropriate box(es) below:

DO	DO NOT

A. Release of medical record except: any information relating to HIV testing, AIDS and AIDS-related syndrome: and psychological information; or alcohol substance abuse treatment information related to my condition, care, and confinement (initial appropriate box)

B. Release of any records regarding HIV testing, AIDS and AIDS-related syndrome: related to my condition, care, and confinement (initial appropriate box)

C. Release of any records psychiatric and psychological (mental health records) related to my condition, care, and confinement (initial appropriate box)

D. Release of all dental records related to my condition, care, and confinement (initial appropriate box)

E. Release of any records regarding alcohol and/or substance abuse treatment information related to my condition, care, and confinement (initial appropriate box). I understand that my records are protected under the federal regulation governing *confidentiality of alcohol and Drug abuse patient Records* 42 U.S.C. § 290 (dd) (2). And cannot be disclosed without my written consent unless otherwise provided for in the regulation. 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 (dd) (2), Fed. 42 Rule, C.F.R. part 2.

_____

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

_____

(specification of the date, event, or condition upon which this consent expires if less than six months)

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and for any event, this consent shall be effective for six months unless I specify a different expiration as follows:

_____

In furtherance of this authorization, I (we) do hereby waive all provisions of the law and privileges relating to the disclosures hereby authorizes. 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 boxes above.

_____

SIGNATURE OF PATIENT (OR NEXT OF KIN, GUARDIAN OR AUTHORIZED REPRESENTATIVE, WHEN REQUIRED) *

STATE OF FLORIDA)

COUNTY OF _____)

Personally known_____ or produced identification

Type of identification produced _____

_____

NOTARY PUBLIC SIGNATURE

Print, type, or stamp commissioned name of Notary Public

My Commission expires: **SEAL**

_____

*CONSENT FOR INSPECTION AND/OR RELEASE OF CONFIDENTIAL INFORMATION

C4-11B (2/97)

AUTHORIZATION FOR MEDICAL INFORMATION

Records Department

Date: _____

To Whom It May Concern:

This authorizes the physicians, hospital and all medical attendant's including the County Sheriff's Department, to furnish full and complete medical reports and information requested by the undersigned to:

_____

This authorization also includes examination of all hospital medical records, x-ray film, medical psychiatric, drug, alcohol, substance abuse testing, HIV testing or ARD and AIDS information in my records.

Your full cooperation is required.

All prior authorizations are hereby canceled.

/S/ _____

_____

DC# _____

_____

_____

_____