GREENE COUNTY PUBLIC DEFENDER

AUTHORIZATION TO RELEASE INFORMATION

I, _____, D.O.B._____ do hereby authorize any employee of the Office of the Greene County Public Defender to share information about my case, including the contents of my file unless otherwise specified, with the persons or agencies listed below, as well as to receive information from said agencies in order to assist with my legal representation.

Name of person/agency_____ Relationship to client_____

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Specific information to be released (indicate by initialing):

Education/School _____ Employment_____

Mental health _____ Substance Abuse treatment _____

For releases to Substance Abuse Facilities/Counselors:
I understand that chemical dependency records are protected under 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the Federal Privacy Regulation under 45 CFR sec. 164.524).

Limits on disclosure (specific information you do not want shared by this office or another agency):
_____
_____

This authorization shall terminate on:_____ (You may designate a particular date, a period of time, such as "2 years from this date", or an event, such as the conclusion of your court case.)

I understand that I may revoke this authorization at any time by re-executing this document.

All my questions about this form have been answered, and I have been provided a copy.

_____ Date:_____
Client signature

_____
Witness name and title

_____ Date:_____
Witness signature