

FEDERAL PUBLIC DEFENDER
EASTERN DISTRICT OF MISSOURI

LEE T. LAWLESS
FEDERAL PUBLIC DEFENDER

1010 Market St.
Suite 200
St. Louis, MO 63101

(314) 241-1255
FAX (314) 421-3177

Authorization for Release of Protected Health Information

The Federal Public Defender's Office is the attorney-in-fact for the patient named below, and covered entities must release PHI to patients or their personal representatives upon request. 45 CFR 164.524. This request is not subject to the "Minimum Necessary" requirement pursuant to 45 CFR 164.502(b)(2)(ii).

Patient: _____ **Former Name (if any):** _____

Birthdate: _____ **Social Security Number:** _____

I hereby authorize _____ (hospital/physician) to release protected health information (PHI) to the Federal Public Defender's Office. Dates of treatment are/were: _____. The purpose of the disclosure is: _____

Information to be Disclosed (circle all that apply):

Complete Medical Record	Immunization Record	Emergency Reports	EKG
Physician Notes	X-Ray Reports	Laboratory Reports	Consultation Reports
Medication Lists	History and Physical	Operative Reports	Discharge Summary
Other (please specify): _____			

Disclosures Requiring Special Authorization: I specifically authorize disclosure of information relating to the following highly confidential areas (circle all that apply):

Alcohol or Substance Abuse Mental Health/Developmental Disabilities AIDS/HIV Testing or Treatment
Sexually Transmitted Diseases/Communicable Diseases

I understand the information contained in this request is protected by the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA). I understand that once this information is released, used, or shared, the recipient may use the information again without my permission, and the information is no longer protected by applicable privacy laws. I understand the physician or hospital providing these records cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand this authorization is voluntary and I may revoke this authorization by contacting my attorney in writing and naming a date, time, condition, or event upon which this authorization will expire. I understand that revocation of this authorization will not apply to information that has already been released under this authorization. This form has been explained to me and I understand its contents. Unless otherwise specified, this authorization will expire in one (1) year. This authorization is designed to comply with 45 CFR 164.508. A photocopy or facsimile of this authorization shall be as valid and effective as the original.

Patient/Legal Representative: _____ Date: _____

If signed by legal representative, state relationship to patient: _____
Reason patient is unable to sign: _____

Witness: _____ Date: _____

**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT
INFORMATION PURSUANT TO 45 CFR 164.508**

TO:

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

Street Address

City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- ☐ All employment, personnel or wage records.
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human

immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative
(See 45CFR § 164.508(c)(1)(vi))

Date

Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR § 164.508(c)(1)(iv))

Witness Signature

Date

OFFICE OF THE FEDERAL PUBLIC DEFENDER
DISTRICT OF MARYLAND

NORTHERN DIVISION
100 S. CHARLES STREET TOWER II, SUITE 1100
BALTIMORE, MARYLAND 21201
TEL: (410) 962-3962
FAX: (410) 962-0872

JAMES WYDA
FEDERAL PUBLIC DEFENDER

AUTHORIZATION FOR DISCLOSURE OF PSYCHOTHERAPY NOTES

Patient's Name: _____

My Social Security Number or Patient Record Number is: _____

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information:

Name: _____

Organization(s): _____

Address: _____

2. I authorize the following person(s) and/or organization(s) to receive my protected health information:

Name: _____ Title: _____

Office of the Federal Public Defender
100 S. Charles Street, Tower II, Suite 1100
Baltimore, Maryland 21201

Phone: (410) 962-3962
Fax: (410) 962-0872

6411 Ivy Lane, Suite 710
Greenbelt, Maryland 20770

Phone: (301) 344-0600
Fax: (301) 344-0019

for the following purposes:

(Describe purpose--may include "at my request" if authorized by individual on whom PHI is kept)

3. The authorization herein granted is for the release of my psychotherapy notes recorded (in any medium) by a health care provider who is a mental health professional, documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session. This includes records that the disclosing person(s) and/or organization(s) received from another health care provider, where redisclosure is not prohibited. This authorization does not cover the disclosure of psychotherapy notes, or parts of psychotherapy notes, that relate to and identify other persons in group or family therapy absent authorization from those identified persons or their representatives.

4. This authorization will expire on: _____
(Expiration date or event, which may be no longer than 1 year)

5. I understand that I may revoke this authorization in writing at any time except to the extent that the disclosing person(s) and/or organization(s) has(have) already taken action in reliance on this authorization.

6. I understand that information disclosed pursuant to this authorization, may be redisclosed by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 C.F.R. Parts 160 and 164. I hereby authorize the Office of the Federal Public Defender to redisclose my medical records as needed for use in _____.

(Provide case name and number)

7. I understand that this authorization is voluntary. I understand that my treatment, payment for my health care, enrollment or eligibility for benefits will not be affected if I do not sign this form.

8. A photocopy of this release may be honored. You may send copies of my health record to the Office of the Federal Public Defender by facsimile or mail.

Signature of Patient or Patient's Representative

If Patient's Representative: Relation To Patient

Date

Patient's Name (Please print)

Patient's Date of Birth

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at <http://www.archives.gov/veterans/evetrecs/> *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)		2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH		
5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)						
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						
6. IS THIS PERSON DECEASED? If "YES" enter the date of death. ☐ NO ☐ YES _____			7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE? ☐ NO ☐ YES			

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

- ☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. Check the appropriate box below to specify a deleted or undeleted copy. When was the DD Form(s) 214 issued? YEAR(S):
- ☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.
- ☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.
- ☐ **All Documents in Official Military Personnel File (OMPF)**
- ☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, provide facility name and date for each admission:
- ☐ **Other** (Specify):

2. **PURPOSE:** (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

- ☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal
- ☐ Other, explain:

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER IS:** (Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)

- ☐ Military service member or veteran identified in Section I, above
- ☐ Next of kin of deceased veteran (Must provide proof of death).

Show relationship: _____

(See item 2a on accompanying instructions.)

- ☐ Legal guardian (Must submit copy of court appointment.)
- ☐ Other (specify) _____

2. SEND INFORMATION/DOCUMENTS TO:

(Please print or type. See item 4 on accompanying instructions.)

3. **AUTHORIZATION SIGNATURE REQUIRED** (See items 2a or 3a on accompanying instructions.) I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Name

Signature Required - Do not print

Street

Apt.

Date of this request

Daytime phone

City

State

Zip Code

Email address

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name

Date of Birth

Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME

ADDRESS

FEDERAL DEFENDERS
1010 MARKET, SUITE 200
ST. LOUIS, MO. 63101

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- ____ Social Security Number
- ____ Identifying information (includes date and place of birth, parents' names)
- ____ Monthly Social Security benefit amount
- ____ Monthly Supplemental Security Income payment amount
- ____ Information about benefits/payments I received from _____ to _____
- ____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- ____ Medical records
- ____ Record(s) from my file (specify) _____
- ____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

FEDERAL DEFENDERS OF WESTERN NORTH CAROLINA, INC.

1 Page Avenue, Suite 225
Asheville, NC 28801

Claire J. Rauscher
Executive Director

Phone (828)232-9992
Facsimile (828)232-5575

Authorization to Release Non-Medical Records

Re: _____
Date of Birth: _____
Social Security No: _____

I, _____, do hereby AUTHORIZE and REQUEST the following companies, agencies, persons, and institutions to release to a representative of my attorney, Federal Defenders of Western North Carolina, Inc., certified copies of ALL records and other information relating to me. This includes, without limitation:

Treatment	(Initial)	Drug & Alcohol	(Initial)
Immigration	(Initial)	Law Enforcement	(Initial)
Real Estate	(Initial)	Employment	(Initial)
Telephone	(Initial)	Gas & Electric	(Initial)
Other _____	(Initial)		

(I understand only the information initialed will be released.)

Request directed to: _____

To the extent that any federal, state, or local laws or regulations enacted to protect the privacy of said records would otherwise prevent their release or examination. I hereby waive the protection of such laws and regulations.

Date

Signature

OFFICE OF THE FEDERAL PUBLIC DEFENDER
DISTRICT OF MARYLAND

NORTHERN DIVISION
TOWER II, SUITE 1100
100 SOUTH CHARLES STREET
BALTIMORE, MARYLAND 21201-2705
TEL: (410) 962-3962
FAX: (410) 962-0872

JAMES WYDA
FEDERAL PUBLIC DEFENDER

SARAH S. GANNETT
STAFF ATTORNEY

Date

Via Facsimile:

Elementary School
Address
City, State ZIP

ATTN: Records Custodian

Re: Client
D/O/B:
SSN:

Dear Records Custodian:

The Office of the Federal Public Defender has been appointed to represent Client in a case currently pending in the United States District Court for the District of Maryland. Client's education records are necessary to our representation of him/her.

It is my understanding that Client attended School from (date) until (date). (Alternatively: I regret that I cannot give you the specific year.) Please be kind enough to provide us with copies of any and all records pertaining to Client, including, but not limited to, academic records, attendance records, disciplinary records, medical or mental health records, counseling records, etc. I have enclosed an Authorization for Release of Information signed by Client.

Please feel free to call me with any questions you may have concerning this request. Thank you, in advance, for your assistance in this matter.

Sincerely,

Sarah S. Gannett
Staff Attorney

Enclosure