✎ PROB 11A
(9/77)

UNITED STATES DISTRICT COURT
FEDERAL PROBATION SYSTEM

AUTHORIZATION TO RELEASE CONFIDENTIAL MILITARY INFORMATION

NAME (Last, First, Middle)	DATE OF BIRTH	DATE SIGNED

The above named individual is a defendant before the U.S. District Court for the _____

District of _____

The requested documents are necessary to complete an official report ordered by this court.

I authorize release to the United States probation office all confidential records and information concerning me, including any information contained in a system of records of a government agency or other agencies and facilities subject to the Privacy Act or similar restrictions.

This authorization shall remain in effect until it is revoked in writing.

_____ _____
(Signature of Defendant) (Date)

WITNESS: _____ _____
(Signature of Probation Officer) (Date)

AUTHORIZATION FOR RELEASE OF MILITARY MEDICAL PATIENT RECORDS (Drug Rehabilitation)

The National Personnel Records Center, General Services Administration, is hereby authorized to release copies of my military medical treatment records as described below.

NAME OF PERSON AUTHORIZED TO RECEIVE RECORDS

NAME AND ADDRESS OF FACILITY TO RECEIVE RECORDS

PLACE WHERE TREATMENT OCCURRED	APPROXIMATE PERIOD OF TREATMENT

SPECIFIC TYPE OF TREATMENT INVOLVED

PURPOSE FOR WHICH RECORDS ARE NEEDED

THIS AUTHORIZATION EXPIRES WITHOUT EXPRESS REVOCATION 12 MONTHS FROM THE FOLLOWING DATE.

DATE	SIGNATURE OF INDIVIDUAL WHOSE RECORDS ARE REQUESTED

Print Reset

✎ PROB 11B
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
DRUG ABUSE PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)
information in its records, possession, or knowledge, of whatever nature may now exist or come to exist to the United States Probation Office of the _____ District of _____ .
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with my participation in the aforementioned program which has been made a condition of my _____ (pretrial release, post-trial release, probation, or parole).

I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court and/or United States Parole Commission when necessary for the purpose of discharging its supervisory duties over me.

I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

Print Reset

✎ PROB 11E
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PROGRAMS

I, _____, the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)
information in its records, possession, or knowledge of whatever nature may now exist or come to exist to the United States Probation Office of the _____ District of _____.
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); psychotherapy notes; date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with the preparation of a court-ordered report.

I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court.

I understand that this authorization is valid until I have been sentenced and my sentence is final, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before the completion of the presentence investigation will be reported to the court.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

Print Reset

✎PROB 11G
(Rev. 5/03)

AUTHORIZATION TO RELEASE INFORMATION
(PRIVATE PERSON OR ORGANIZATION)
TO PROBATION OFFICER

TO WHOM IT MAY CONCERN:

I, _____, the undersigned, hereby authorize the United States Probation Office for the _____ District of _____, or its authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

- ☐ Employment
- ☐ Education Records (including, but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)
- ☐ Medical Records
- ☐ Psychological and Psychiatric Records

I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the United States Probation Office's official use.

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency; any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____.
(Name and Address of Program)

Regarding protected health information, I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____	_____	_____
(Authorizing Signature - Full Name)	(Full Name - Printed or Typed)	(Date)
WITNESS —	_____	_____
	(Probation Officer)	(Date)

Print Reset

✎PROB 11H
(Rev. 5/03)

AUTHORIZATION
TO RELEASE GOVERNMENT (STATE OR FEDERAL) INFORMATION
TO PROBATION OFFICER

I, _____, the undersigned, hereby waive my rights under the Privacy Act, 5 U.S.C. 552a (Supp. IV, 1974), and authorize the disclosure to the United States Probation Office of the _____ District of _____, or its authorized representative(s) or employee(s), any and all information pertaining to me, contained in the files or systems of records maintained by any government agency subject to the Privacy Act, which such agency sees fit to convey, either orally or in writing, to the aforementioned Probation Office.

I hereby waive any rights I may have under the Privacy Act to prior notice of such disclosure, or of any rights I may have to an accounting of such disclosure to the aforementioned Probation Office.

I understand that this authorization will be used by the aforementioned Probation Office to request disclosure of information pertaining to me from any or all federal or state agencies.

This information is to be obtained for the purpose of conducting a presentence investigation and making a report or for supervision.

Regarding protected health information, I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

Regarding protected health information, I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires this information will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

Authorizing Signature (full name)	Full Name (printed or typed)	Date
	Parent/Guardian Signature, if Required	
	Attorney Signature, if Available	
WITNESS —	Probation Officer	Date

Print Reset

PROB 11I
(Rev. 12/12)

UNITED STATES PROBATION SYSTEM

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION MENTAL HEALTH TREATMENT PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)

information in its possession to the United States Probation Office in the _____ .
(Name of Court)

The confidential information to be released will include: date of entrance to program; attendance records; drug detection test results; type, frequency, and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (e.g., psychological, psycho-physiological measurements, vocational, sex offense specific evaluations, clinical polygraphs); date of and reason for withdrawal or termination from program; diagnosis; and prognosis.

This information is to be used in connection with my participation in the above-mentioned program, which has been made a condition of my post-conviction supervision (including probation, parole, mandatory release, supervised release, or conditional release), and may be used by the probation officer for the purpose of keeping the probation officer informed concerning compliance with any condition or special condition of my supervision. I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) *(Date Signed)*

_____ _____
(Signature of Client) *(Date Signed)*

_____ _____
(Name & Title of Witness) *(Date Signed)*

Print Reset