REQUEST FOR MEDICAL HISTORY DATA

TO WHOM IT MAY CONCERN:

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

___ Medical Treatment ___ Psychological and Psychiatric Treatment __ Alcohol and Drug Treatment

which occurred on or about: _____

Specific information requested:

___ Intake/Initial Interview	___ Lab, X-Ray, EKG	___ Progress Notes
___ Discharge Summary	___ Social History	___ Prescribed Medications
___ History and Physical	___ Psychiatric Evaluation	___ Nursing Notes
___ Operative Record	___ Psychological Evaluation	___ Other
___ Pathology Record	___ Psychological Test Results	_____
___ Emergency Room Record	___ Education Test Results	_____

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, from any and all liability for damages of whatever kind which may at any time result to me, my family, heirs, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

I understand 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 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 if I am under a condition of supervision to participate in a program that requires this authorization, revoking this authorization before I satisfy the condition will be reported to the court and may be considered a violation of a condition of supervision.

_____	_____	_____
Signature	Full Name - Printed	Date
_____		_____
Probation Officer		Date

Prohibition on Redisclosure: This information has been disclosed to the U.S. Probation Office and District Court from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the U.S. Probation Office from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

June 2003