

**AUTHORIZATION TO RELEASE CONFIDENTIAL MILITARY INFORMATION**

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