INVESTIGATING THE MITIGATION & FINDING THAT LOWER SENTENCE

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WHAT I WANT TO ACCOMPLISH

What is mitigation?
How do we find it?
How to present it?
How else can I use the information?

MITIGATION MADE SIMPLE

I want to gain information about my client's life

18 U.S.C § 3553(a)

- Nature & circumstance of the offense
- History & characteristics of the defendant
- The kind of sentences available
- The kind of sentence & established sentencing range
- Pertinent policy statements
- Avoid unwarranted sentencing disparities
- Need to provide restitution to any victims

Evidence Collection

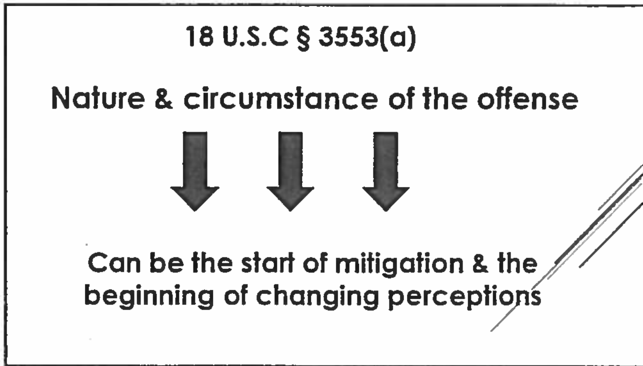
On Nature & Circumstance

- What is the charge, nature of the offense?
- Players involved?
- Experts?

18 U.S.C § 3553(a)

Nature & circumstance of the offense

- Is my case markedly different OR is my case the same
  - The same evidence formed the basis for conviction on all three offenses.
  - Case is not different than other child porn cases being prosecuted
  - No allegation defendant attempted to entice children or physically abused
  - "use of a computer" to download child pornography is not exactly a remarkable fact
  - We are NOT questioning guilty or lack of responsibility, but simply pointing out the nature of the offense



18 U.S.C § 3553(a)

History & characteristics of the defendant

I want to gain information about my client's life

Evidence Collection On Nature & Circumstance

- What is the charge, nature of the offense?
- Players involved?
  - Client
  - Witness
  - CI
  - AUSA/Officers
- Experts?
  - ME, Ballistics, Etc.

Mitigation Collection

- What is the charge, nature of the offense?
- Players involved?
  - Client
  - Family
  - Friends
  - Treating professional
- Experts?
  - Psychologist, Psychiatrist, Etc.

1st Meeting

Medical
Psychiatric
Family History
Criminal History
Education
Job History

What Are They Not Saying

- Using big words in the wrong context
- Unable to read social cues
- Physical appearance; unable to perform basic self care
- Signs of abuse
- Unable to stay focused, racing thoughts, pressured speech
- Unable to stop crying
- Tics

Keep In Mind

- What makes your client different to you?
- How is he/she unique?
- How to present in a favorable way?
- Extraordinarily challenged or gifted?
- Overcoming extreme diversity?

RECORDS

- Medical
- School
- Mental Health
- Prior Counsel
- Prior Incarceration
- Evaluations
- Social Security Disability
- Social Media
- Family Member's Records
- Community/Neighborhood
- Religion

Public Records Request

FOIA

- http://www.foia.gov/

Tennessee Public Records

- https://www.comptroller.tn.gov/openrecords/law.asp

INTERVIEWS

- Family
- Friends
- Employer
- Former Counsel
- Jail Staff
- Teachers

18 U.S.C § 3553(a)

The kind of sentences available

The kind of sentence & established sentencing range

18 U.S.C § 3553(a)

The kind of sentences available
The kind of sentence & established sentencing range

- Home Confinement
- Inpatient Treatment
- Split Sentence

18 U.S.C § 3553(a)

Pertinent policy statements
Avoid unwarranted sentencing disparities

"receipt" and "possession" of child pornography involve virtually indistinguishable conduct but the sentencing disparity between the two separate offenses is significant.

Other Ways To Use Mitigation To Your Advantage

- Mitigation facts can prove helpful in case prep
- Plea negotiations
- No superseding charges
- Alternate sentences
- Helping client to accept a plea offer
- Target letters
- Better rapport with client

PRESENTING YOUR INFORMATION

- Witnesses
- Tell the Story Yourself – ENJOY THE FREEDOM
- Video's
- Support Letters
- Sentencing Memo's

RECORD REQUESTS

Knox County Detention Center

Medical Records: Fax Request Letter and HIPPA Compliant Release
Margaret
281-6709
281-6701

Blount County Detention Center

Fax HIPPA compliant release and request letter to:
Risk Management
Fax: 423-305-6979

Claiborne County Jail

Fax a HIPPA complaint release to:
Fax: 423-526-2046

TDOC Archived Records

Requests should be submitted in writing by fax, mail or email.
Tennessee Department of Correction
Records Management
2nd Floor, Rachel Jackson Building
Nashville, Tennessee 37243-0465
FAX (615) 532-1497

You will need to include the following information with your request:

- Your Contact Information - name, mailing address, phone number and an email address
- Person You Are Requesting Information On - full name, date of birth, TOMIS #, etc. (list any information available that will help us to make a positive ID.)
- Detailed Description of Information Seeking From The Record.

If an archive search is required, there will be a charge of 15 cents per page. Do not send a payment with your original request. You will be contacted with a cost estimate when the search is complete. The information will be mailed to the address provided when payment is received

You will need the inmates TOMIS ID #. This can be found at: https://apps.tn.gov/foil/

TDOC Archived Medical Records

615-253-8017

Call first, with the name, dob and TOMIS ID #, and they will refer you to the correct fax #. Medical records are stored at several different sites.

Knox County Schools

Records UP TO 2003, are held at a central location.
Fax a release and request letter to Ginger
Fax: 865-215-5665
865-215-5656

List the last school the student attended and whether they graduated.

Any records since 2003, are being held at the last school the student attended. Contact the specific school and fax them a release and request for records.

IF your client received special education services, those records are held separately. Contact, Kelly, 865-594-1516 to request special education records. A general release should still be sufficient.

Helen Ross McNabb
*Require their own release
Will accept by fax
Fax: 865-637-1278

Phone: 1-800-255-9711

Helen Ross McNabb Center
ATTN: Records
201 W. Springdale Avenue
Knoxville, TN 37917

Peninsula/Covenant Health
*Require their own release
Will accept by fax

Fax: 865-374-2038
Phone: 865-374-5269

Cherokee Health Systems
Use HIPPA compliant release and send to specific office they received treatment

Frontier Health
HIPPA Compliant Release
Will accept by fax

Fax: 423-467-3710
Phone: 423-467-3600

Frontier Health
ATTN: Medical Records
P.O. Box 9054
Johnson City, TN 37615

Generally speaking all hospitals will accept a HIPPA compliant release & will accept a request letter via facsimile.

Insert Letterhead

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME:
SSN:
DOB:

1. I authorize the disclosure of my protected health information [1] and psychotherapy notes, including records that may contain information about the Human Immunodeficiency Virus (HIV) or other communicable diseases. I understand that this authorization is voluntary. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws. The information, once disclosed, may be subject to re-disclosure and may no longer be protected under Federal Law.

2. I authorize the following person(s) and/or organization(s) to disclose my protected health information and psychotherapy notes, including records that may contain HIV-related information: ____________________

Insert name of agency/person you are requesting records from

3. As disclosed by the person(s) and/or organization(s) above, I authorize the following person(s) and/or organization(s) to receive my protected health information and psychotherapy notes, including records that may contain HIV-related information. This information is necessary to assist with my legal defense:

Insert your name and where you want the records sent

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[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protested, the information must be such that identifies the individual or provides a reasonable bases to believe that the information can identify the individual. 45 C.F.R. 164.508

4. A photocopy of this release may be honored. I specifically authorize the disclosure of the following health information:

_____ Emergency Room Records
_____ Hospital Inpatient Records
_____ Laboratory & Diagnostic Finding
_____ HIV-Related Information
_____ Psychotherapy Notes
_____ Hospital Outpatient Records
_____ Mental Health Treatment Records
_____ Substance Abuse Treatment
_____ Office Based Records
_____ Billing Information

5. I am aware that confidential HIV-related information is any information indicating that I had an HIV-related test, or have an HIV infection, HIV-related illness or AIDS, or any information which indicates that I have potentially been exposed to HIV. I understand that, under New York State law, except for certain people, confidential HIV-related information can only be given to persons I allow to have it by signing a release. I am aware that I may ask for a list of people who can be given my confidential HIV-related information without a release form.

6. I am aware that by signing this authorization, my protected health information and psychotherapy notes, including any HIV-related information, can be given to the people listed above. I understand that I can refuse to sign this authorization, and am aware that I do not have to allow the release of HIV-related information or any other protected health information or psychotherapy notes. I also know that I can change my mind, and that I may revoke this authorization in writing at any time by sending a signed and dated written statement to the Federal Defender Services of Eastern Tennessee, Inc., saying that I am revoking my authorization to disclose protected health information and psychotherapy notes, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

Date your authorization to expire 1 year from signing date

This authorization expires on _______________.

I have had the opportunity to read and consider the content of this authorization. I confirm that the contents are consistent with my direction.

______________________________ ______________________________
Signed Date

INSERT YOUR LETTERHEAD

RELEASE OF INFORMATION

I, ______________________________________, Date of Birth ___________,

Social Security Number _________________, do hereby authorize

____ to

release to ____________________ all of my records and information. This

authorization includes the right to copy, receive and inspect all records.

This authorization expires on ______________.

________________________________ Signed

______________ Dated

HELEN ROSS McNABB CENTER (HRMC)

Authorization to Release Protected Health Information

HRMC Case #:____________________

Client's Name:____________________

Date of Birth: ________ Soc.Sec.#: ____________

Phone #:____________________

I authorize the use or disclosure of the above named individual's health information as described below.
I hereby authorize:
☐ HRMC INC, ______________________________ ☐ Other Name/Agency Address: ______________________
(Specify HRMC Service)
City______________ State________ Zip________

The information identified below may be used by or disclosed to the following individuals(s) or organization(s):

Name:______________________ Address:______________________

Phone: ______________________

Fax: ______________________ City______________ State________ Zip________

Indicate the time period that is to be disclosed: Time Period ____________ to ____________.

If the information to be used/disclosed contains any of the types of records or information italicized below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my *initials* in the applicable space next to the type of information:

_____*HIV/AIDS* _____*Genetic* _____*Alcohol/Drug* diagnosis, treatment or referral information (Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information is to be disclosed.)
Please check either All or Limited to indicate how much Alcohol/ Drug information is to be disclosed:

_____All A&D information or _____Limited A&D information (specify by checking the applicable choices below.)

Indicate the information that is to be disclosed for Social Services, Medical and/or Mental Health by checking the choices below:
☐ Diagnosis ☐ Progress Report(s) ☐ Assessments ☐ Prescribed Medication
☐ Treatment Plan ☐ Discharge Summary ☐ Evaluations ☐ Labs
☐Other____
(Specific or meaningful fashion)

The purpose of the use or disclosure is: ☐ at the request of the individual; ☐ coordination of care;
☐ Other, (specify)______________________________
(Descriptive or specific reason)

Unless I specify differently, this authorization will expire on the following date, event, or condition specified; automatic expiration will occur in ☐ 60 days ☐ 90 days ☐ 180 days, event or condition ______________________
If I fail to specify an expiration date or event, this authorization will expire in one hundred and eighty days from the date on which it was signed or at termination of treatment, whichever occurs first. *Health information may relate to my past, present, or future physical or mental health or condition, the provision of my health care, or payment for my health care services.*

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. and submit my revocation to the HRMC Privacy Officer or designee. I understand that the revocation will not apply to information that has been disclosed or used in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the use of this disclosure for the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that the Helen Ross McNabb Center will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign the authorization.

I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be redisclosed by the receiving party. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, genetic testing information and drug/alcohol diagnosis, history, treatment, referral or rehabilitation for substance abuse, therefore prohibiting the receiving party from re-disclosure without my consent.
Electronic copies of this Authorization or any amendments hereto shall be binding upon the parties. and electronic reproduction of signatures appearing herein or on any reproduction shall be deemed to be original signatures.

I understand that I may receive a copy of this signed authorization form.

I have read, or have had read to me, the above statements and understand them as they apply to me.

______________________________ ______________________
Signature of client or legal representative Date

If not signed by client, relationship to client______________________

Peninsula, a Division of Parkwest Medical Center

Authorization to Release Protected Health Information

I, ______________________________, hereby authorize ☐ Peninsula Hospital

☐ Peninsula Outpatient Services, please specify which Clinic/Service: ____________________

☐ Other, specify: ____

to disclose health information regarding the following patient:

Patient Name: ______________________________ Date of Birth: ____________________

Address: ______________________________

Phone: ______________________________ Date of Death: ____________

The information is to be disclosed to the following persons or organizations: ____________________

____

The purpose of the use or disclosure is: ☐ at the request of the patient; ☐ coordination of care; ☐ other, (specify) ____

Information to be Disclosed. The information to be disclosed includes only those items checked below, for the following dates of service ____________________ or on or around ____________________.

- ☐ Entire medical record
- ☐ Admission Medical Assessment
- ☐ Psycho-Social Assessment (if applicable)
- ☐ Medication Administration Records
- ☐ Other (specify): ____________________
- ☐ Annual Update
- ☐ Intake Assessments
- ☐ Lab Results (if performed)
- ☐ Billing/Payment Records (specify)
- ☐ Discharge Summary
- ☐ Treatment Plan
- ☐ X-ray results (if performed)
- ☐ Verbal Communication

PSYCHOTHERAPY NOTES MUST BE REQUESTED ON A SEPARATE RELEASE

I do______ do not______ authorize release of any substance abuse records.

Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the specific Peninsula facility. However, the revocation will not have any effect on any uses or disclosures the Peninsula facility may have made before the revocation was received.

Expiration. I understand that unless I specify an expiration date or revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed. Specify Expiration Date: ______________________________.

Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party. However, if the information contains reference to diagnosis, history, treatment, or rehabilitation for substance abuse, then federal law may prohibit the receiving party from re-disclosure without my consent.

Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Peninsula facility will not condition treatment on whether I sign this Authorization.

Certification. I certify that I am *(check whichever applies)*:

- ☐ the patient, 16 years or older, and the identification that I have provided is true and correct.
- ☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: ____________________.
- ☐ the attorney in fact under a power of attorney who has the right to make disclosures under the power
- ☐ the patient's guardian ad-litem for the purposes of the litigation in which the guardian ad-litem serves.
- ☐ the treatment review committee for a patient who has been involuntarily committed.
- ☐ the executor, administrator or personal representative on behalf of a deceased patient. (You must include the documents that furnish proof of authority.)

Signed this ______ day of ______________________________, 20____.

Patient Signature: ____________________ Witness: ____________________

Authorized Representative Signature: ____________________ Print Name: ____________________

Print Name: ____________________ Phone: ____________________

Address: ____________________

____

Phone: ____________________ Chart No: ____________________

Tennessee Department of Labor and Workforce Development
Division of Adult Education

REQUEST FOR OFFICIAL TENNESSEE HIGH SCHOOL EQUIVALENCY VERIFICATION, TRANSCRIPT OR DUPLICATE DIPLOMA

Allow 2-3 weeks for delivery.

This form is for Tennessee students only. If you received an equivalency diploma in another state, you may contact the agency that issued the credential in that state. Do not complete this form to obtain a copy of a regular high school diploma/transcript. For duplicates or regular high school diplomas, contact the Tennessee Department of Education, or click on the following link: Tennessee Public High Schools only – DUPLICATE DIPLOMA REQUEST

Check the documents requested:

☐ Copy of test scores *(transcript)* ☐ Duplicate copy of diploma ☐ Verification letter

PLEASE PRINT

Name: ***(Your legal name at time of testing.)***

____
(First) *(Middle)* *(Last)*

Year test was taken: ________ *(If not certain, give approximate year.)* Date of Birth: ____________

Social Security Number: ______________ Phone Number with Area Code: ______________

Test Site (City / County / Job Corps / Military Location): ______________________

PRINT NAME AND ADDRESS TO WHICH DOCUMENTS SHOULD BE MAILED.

(Note: Colleges that require official copies of diplomas and/or transcripts must receive the documents mailed to them directly from this office or unopened in a state sealed envelope.)

WE CANNOT FAX TRANSCRIPTS OR DIPLOMAS.

Name: ____
(First) *(Middle)* *(Last)*

Address: ____
(Street) *(Apartment or Unit Number)*

____
(City) *(State)* *(Zip Code)*

Please provide the following for verifications only:

Fax: ______________ OR Email: ______________________

I hereby certify that all information provided is completely true and I authorize the release of my scores.
It is MANDATORY that you sign this form before returning it or we cannot process your request.

Signature *(Required)*: ______________________ **Date:** ____________

Email, Fax or Mail this form to: Tennessee Department of Labor and Workforce Development
Division of Adult Education/Testing Services
220 French Landing Drive
Nashville, TN 37243-1002
Fax: 615-532-4899 or 615-532-7048
Email: TNAE.testingservices@tn.gov

LB-0986 (Rev. 07-14) RDA 3045

TENNESSEE DEPARTMENT OF CORRECTION

AUTHORIZATION FOR RELEASE OF HEALTH SERVICES INFORMATION

____
INSTITUTION

INMATE NAME (PRINTED) ______________________ TDOC NUMBER__________

SOCIAL SECURITY NUMBER __________ DATE OF BIRTH __________ GENDER ______

☐ I hereby authorize ______________________ to release the
(NAME OF PROVIDER/FACILITY)
information indicated below to the Tennessee Department of Correction (TDOC) regarding my medical treatment.

TDOC Facility Name: ______________________

Facility Address: ______________________

Phone Number: ______________ Fax Number: ______________

☐ I hereby authorize the Tennessee Department of Correction to release the information indicated below to the following:

Name: ______________________ Relationship to Inmate: ______________

Address: ______________________

Address 2: ______________________

Phone Number: ______________ Fax Number: ______________

Please release the following information (Check "✓" all that apply):

☐ Health Record ☐ Infectious Disease Record ☐ Dental Record ☐ Mental Health Record ☐ Psychotherapy Notes
☐ Substance Use Diagnosis/Treatment ☐ Other ______________ dates ___/___/___ through ___/___/___

Note: An authorization for the release of psychotherapy notes cannot be made in conjunction with an authorization for the release of any other confidential health information. An authorization to release psychotherapy notes must be executed separately from any other authorization for disclosure.

- This authorization expires six (6) months from the date of the signature below and covers only information created prior to that date. I understand that I may retract this authorization at any time, in writing, to the attention of: TDOC Division of Operational Support Services. Rachel Jackson Building, 320 Sixth Avenue North, Nashville, TN 37243-0465.
- I understand that any release, which was made prior to a retraction hereof, and based on this signed authorization, will not constitute a breach of my privacy rights.
- I understand that this authorization is necessary to release information that is deemed private and confidential by law (health records, TCA 10-7-504, mental health records, TCA 33-3-103).
- I understand that a provider may not condition treatment on whether or not I sign this authorization.
- Although the recipient should obtain my authorization before releasing my private information, I understand that if the recipient chooses to re-disclose this information, TDOC cannot ensure its protection by privacy laws.

The subject of the information must sign this authorization. If the subject is under 18 years of age, it must be signed by a parent or legally appointed guardian. If the subject is not legally competent to sign, or is unable to sign, Authorized Representative (a legally appointed conservator, guardian, or attorney-in-fact appointed pursuant to a durable power of attorney for healthcare) must sign this authorization.

______________________ Inmate Signature ________ Date ______________________ Signature of Parent (if minor) or Authorized Representative ________ Date

______________________ Witness Signature ________ Date

U.S Department of Justice

Certification of Identity

FORM APPROVED OMB NO. 1103-0016
EXPIRES 10/31/13

Privacy Act Statement. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests by mail under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. The purpose of this solicitation is to ensure that the records of individuals who are the subject of U.S. Department of Justice systems of records are not wrongfully disclosed by the Department. Requests will not be processed if this information is not furnished. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a(i)(3).

Public reporting burden for this collection of information is estimated to average 0.50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Suggestions for reducing this burden may be submitted to the Office of Information and Regulatory Affairs, Office of Management and Budget, Public Use Reports Project (1103-0016), Washington, DC 20503.

Full Name of Requester [1] ______________________________

Citizenship Status [2] ______________ Social Security Number [3] ______________

Current Address ______________________________

Date of Birth ______________ Place of Birth ______________

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than $10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than $5,000.

Signature [4] ______________________________ **Date** ______________

OPTIONAL: Authorization to Release Information to Another Person

This form is also to be completed by a requester who is authorizing information relating to himself or herself to be released to another person.

Further, pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to me to:

____

Print or Type Name

[1] Name of individual who is the subject of the record(s) sought.

[2] Individual submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

[3] Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.

[4] Signature of individual who is the subject of the record sought.

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*Authorization to Access, Inspect and/or Obtain a Copy of Health Information

Name: ____
LAST FIRST MIDDLE

Medical Record Number (MRN): ____________________ Date of Birth: ____________________
Address:

____
STREET CITY STATE ZIP CODE

Phone: (___) ____________________ Cell/Work Telephone Number: (___) ____________________

I hereby authorize________________ to disclose my Protected Health Information to the following Designee

____

____

RECIPIENT: Name of person or class of persons to whom ____________________ may disclose my Health Information:

____
Address of the recipient or where my health information should be delivered:

____
STREET CITY STATE ZIP CODE

This information for which I am authorizing disclosure will be used for the following purpose:

- My personal records
- Attorney
- Disability claim
- Continuity of care
- Insurance
- Other (please describe): ______________________________

Type of information to be used or disclosed is as follows *(check the appropriate boxes and include other information where indicated).*

- Entire Record
- EmergencyTreatment
- Discharge Summary
- History and Physical
- Operative Reports
- Consultation Reports
- Other (please describe):______________________________
- Abstract Record
- Radiology Reports
- Pathology Reports
- Physician Orders
- Progress Notes
- Nursing Notes
- Laboratory Reports
- Alcohol / Drug Treatment
- Mental Health Information
- HIV Related Information
- Audit Report- AOD

Date of Treatment: ____________ Date Range of Records: From: ____________ To: ____________

Authorization to Access, Inspect and/or Obtain a Copy of Health Information

- **I acknowledge and hereby consent to the release of information relating to: psychiatric records, psychotherapy notes, alcohol and/or drug abuse records; HIV/AIDS information; genetic testing, and/or sexually transmitted disease information. Please initial** ________

- I understand this authorization will expire on (Date) ____________ or 1 year from the date of this signed authorization.

- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization.

- I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

____
Signature of patient or legal representative Description of Authority Date

Identification verified by: • Driver License • Other picture ID (Name): ____________________ Staff Initials: ______