Court Services and Offender Supervision Agency
for the District of Columbia

RELEASE OF INFORMATION
PRIVACY ACT WAIVER

I, ____ [Name],

hereby authorize and give my prior written consent pursuant to 5 U.S.C. § 552a(b) to the Court Services and Offender Supervision Agency for the District of Columbia, to disclose the information noted below concerning me to the recipient(s) noted below for the purpose noted below.

Information to be disclosed:
Recipient(s):
Purpose of disclosure:

I declare under penalty of perjury that the foregoing is true and correct.

Executed this ______ day of ______________, 201_.

____
Signature

RELEASE OF INFORMATION:
Mental Health Information*

I, ____(Name of offender), hereby consent to the release of the information noted in the box below by ____________________ to the United States Parole Commission and/or the sentencing judge, the prosecutor, the defense attorney (if represented), and to CSOSA Community Supervision Services involved in the criminal case in Docket No. _______. I understand that this information may be disclosed to these parties in open court. This means there is a possibility that persons in the courtroom may hear this information. **If the disclosure is to a recipient other than the criminal justice parties named above, the authorized person(s) or organization recipient(s) is to be noted in the box below.** In authorizing this disclosure of mental health information, I understand that the information will be used for the purpose noted in the box below, both now and for as long as this consent is valid. I understand that I may permit _____________ to release the information specified below to the authorized recipient(s) for a period of up to 365 calendar days from the date of this authorization. If I do not state below when this authorization expires, then it will expire 365 calendar days from the date that I signed this form.

Nature of Information to be Disclosed:
Authorized Recipient (Person or Organization) Other than Criminal Justice Parties:
Purpose of Disclosure:

I understand that this information cannot be redisclosed by the person or organization who receives it without my authorization and that the law requires this notice:

> *The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (D.C. Official Code §§ 7-1201.01 – 7-1208.07). Disclosures may only be made pursuant to a valid authorization by the client or as otherwise provided by that Act. The Act provides for civil damages and criminal penalties for violations.*

I understand that this authorization may be revoked in writing by me except in connection with a life or health insurance policy under D.C. Official Code § 7-1202.02(a)(3). I also understand that I have a right to examine and review my mental health records. I understand that a copy of this waiver will be provided to me as well as the individual responsible for making the actual disclosure(s), and that a copy of this waiver will be placed in my file. Authorization for release of information expires on __________(date cannot exceed 365 calendar days from the date this form is signed).

Signature of Offender: Date Signed:	Offender's Date of Birth: Offender's DCDC Number: Offender's PDID Number:
Witnessed by: Date Signed:	

* "Mental health information" is information acquired by a mental health professional in professional capacity that indicates the identity of a person AND relates to the diagnosis or treatment of the person's mental or emotional condition. D.C. Official Code § 7-1201.01(9). Such information includes, among other things, sex offender treatment, anger management classes, and domestic violence treatment.

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RELEASE OF INFORMATION:
Health Records*

I, ____(Name of offender), hereby consent to the release of the information noted in the table below by _________________ to the authorized person(s) or organization recipient(s) noted in the table below.

In authorizing this disclosure of health information, I understand that the information will be used for the purpose noted in the table below, both now and for as long as my consent remains valid.

Nature of Information to be Disclosed:
Authorized Recipient (Person or Organization):
Purpose of Disclosure:

I understand that this information cannot be redisclosed by the person or organization who receives it without my authorization.

The unauthorized disclosure of HIV/AIDS or cancer information violates the provisions of the District of Columbia Official Code §§ 7-302 and 7-1605, which provide for the confidentiality of HIV/AIDS and cancer patient records. Any HIV/AIDS or cancer information may not be redisclosed by the recipient without my express written consent.

I understand that this consent may be revoked in writing by me at any time, and if not revoked, will expire on _________. I also understand that a copy of this waiver will be placed in my file.

Signature of Offender: Date Signed:	
Offender's Date of Birth:	
Offender's DCDC Number:	
Offender's PDID Number:	
Witnessed by: Date Signed:	

* Note that this form may NOT be used to authorize the disclosure of mental health information. The D.C. Mental Health Information Act requires the use of specific language to authorize the disclosure of such information. See the mental health consent form.

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RELEASE OF INFORMATION:
Substance Abuse Treatment

Name of Offender: __________________ **DCDC No.**__________ **PDID No.**__________ **Date of Birth:** ________

I hereby consent to one of the following :

☐ **Criminal Justice Consent:** I consent to the release of the information noted below by ___________ to the authorized person(s) or organization recipient(s) noted directly below.

I understand that the information noted directly below may be disclosed to the judge presiding in my supervision case, the prosecutor, defense attorney, and CSOSA Community Supervision Services handling my case in Docket _________. I understand that this information may also be disclosed in open court. This means there is a possibility that those in the courtroom may hear this information.

The purpose of and need for this **Criminal Justice Consent** is to inform the criminal justice entities listed above of my attendance and progress in treatment. The information to be disclosed is limited to my diagnosis, my attendance or lack of attendance at treatment sessions, and my cooperation with the treatment program and prognosis.

I understand that this **Criminal Justice Consent** will remain effective and cannot be revoked by me until my involvement in the criminal justice system ends in Docket ___________.

☐ **General Consent:** I consent to the release of the information noted below to the authorized person(s) or organization recipient(s) noted in the box below.

I understand that the information noted below may be released to inform the party named of my participation in drug and/or alcohol treatment as a condition of my release to the community. I understand that my participation in a substance abuse treatment program will be shared with the party named to inform the party of my efforts to remain clean and sober or for the purpose noted below.

I understand that this **General Consent** can be revoked by me at any time except to the extent a disclosure was already made in reliance on it, but if not revoked, it will remain in effect until _______________________________ [provide date or event upon which this consent expires].

Information to be disclosed:

Authorized Person or Organization Recipient for General Consent:

Purpose of Disclosure:

I also understand that any disclosure made as a result of this authorization is bound by Title 42, Code of Federal Regulations, Part 2, which governs the confidentiality of alcohol and other drug abuse patient records, and that the information may not be redisclosed without my express written consent.

Signature of Offender: _______________________ Date Signed: __________
Witnessed by: _______________________ Date Signed: __________