✎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 Denham Springs Addiction Disorders 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 Middle District of Louisiana .
(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:

Louisiana Addiction Services, 1295 Florida Avenue, Suite C
Denham Springs, LA 70826
(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)