✎PROB 11I
(Rev. 4/05)

# UNITED STATES PROBATION SYSTEM
# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
# MENTAL HEALTH TREATMENT PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize Capital Area Center For Adult Behavioral Health to release confidential
(Name of Program)

information in its possession to the United States Probation Office in the Middle District of Louisiana
(Name of Court)

The confidential information to be released will include: date of entrance to program; attendance records; drug detection test 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 (e.g., psychological, psycho-physiological measurements, vocational, sex offense specific evaluations, clinical polygraphs); date of and reason for withdrawal or termination from program; diagnosis; and prognosis.

This information is to be used in connection with my participation in the above-mentioned program, which has been made a condition of my post-conviction supervision (including probation, parole, mandatory release, supervised release, or conditional release), and may be used by the probation officer for the purpose of keeping the probation officer informed concerning compliance with any condition or special condition of my supervision. 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:

Capital Area Center For Adult Behavioral Health
4615 Government Street, Bldg 2, Baton Rouge, LA 70806
(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.

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| (Signature of Parent or Guardian if Client is a Minor) | (Signature of Client) |
| (Date Signed) | (Date Signed) |
| (Name & Title of Witness) | (Date Signed) |