PS 6
(Rev. 6/03)

AUTHORIZATION TO RELEASE INFORMATION
(PRIVATE PERSON OR ORGANIZATION)
TO PRETRIAL SERVICES OFFICER

TO WHOM IT MAY CONCERN:

I, _____, the undersigned, hereby authorize the United States Pretrial Services Office for the _____ District of _____ or its authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

- ☐ Employment
- ☐ Education Records (including but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)
- ☐ Medical Records
- ☐ Psychological and Psychiatric Records

I hereby direct you to release such information. This release is executed with full knowledge and understanding that the information is for the United States Pretrial Services Office's official use.

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency; any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

The information hereby obtained by the aforementioned pretrial services office is to be used only for the purpose of pretrial services investigation and report and, if applicable, for supervision. If I am found guilty, such information will also be made available to the probation office for the purpose of preparing a presentence report, in accordance with federal law.

Regarding protected health information, 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.

Regarding protected health information, 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:

_____ .
(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 pretrial supervision.

_____	_____	_____
(Authorizing Signature—Full Name)	(Full Name—Printed or Typed)	(Date)
WITNESS—		
	_____	_____
	(Pretrial Services Officer)	(Date)