BUCKS COUNTY DEPARTMENT OF CORRECTIONS
AUTHORIZATION FOR RELEASE OF INFORMATION

This form will authorize the release of an inmate's records pertaining only to himself/herself.

- The inmate should initial all applicable boxes in the "Initial" columns in Sections A, B, C and E below.
- Section D may be completed by the requester or another party.
- The inmate and a Department of Corrections employee shall both sign at the bottom of Section F.

A. RECORDS TO BE DISCLOSED (initial all that apply)	Initials	B. NATURE OF INFORMATION TO BE RELEASED (initial <u>all</u> that apply)	Initials
Treatment Records		General Medical/Dental	
Other Records (specify):		Mental Health	
		Drug/Alcohol Addiction/Abuse	
		Other information (specify):	
C. AUTHORIZED TIME FRAME OF RECORDS TO BE DISCLOSED (initial and complete <u>only</u> one)	**Initials**	**D. AUTHORIZED RECIPIENT OF RECORDS AND INFORMATION (name and address of requester)**	
1. All records regardless of date			
2. Only records since the following date: _____			
3. Only records for the time period between _____ and _____			
E. PURPOSE OF DISCLOSURE AND RELEASE (initial <u>only</u> one)	**Initials**		
1. Court proceedings			
2. Other (specify):			

F. ACKNOWLEDGMENTS AND AUTHORIZATION

1. I hereby authorize the Bucks County Department of Corrections to release or disclose to the recipient identified in Section D, for the purpose described in Section E, all records described in Section A, including records containing information described in Section B, during the time period described in Section C.

2. I acknowledge that disclosure of any records (including but not limited to general medical/dental, mental health, and drug/alcohol addiction/abuse) of treatment, testing, or hospitalization may contain information regarding all aspects of my treatment, testing and hospitalization, including information pertaining to a diagnosis, testing or treatment for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or an illness or infection related to HIV or AIDS.

3. I acknowledge that disclosure of any mental health records or information may contain information regarding all aspects of my treatment and hospitalization, including psychological and psychiatric information.

4. In authorizing this disclosure, I explicitly waive any and all rights I may have to the confidential maintenance of these records, including any such rights that exist under local, state, and federal statutory and/or constitutional law, rule or order, including those contained in the Pennsylvania Mental Health Procedures Act, (MHPA) 50 P.S.§§7101et seq., ,the Drug and Alcohol Abuse Control Act, 71 P.S.§§1690.101 et seq., the Confidentiality of HIV-Related Information Act,35 P.S.§§7601et seq., the Criminal History Record Information Act, 18 Pa.C.S. §§9101 et seq.

5. I understand that information will be disclosed to the requester from records whose confidentiality is protected by State statute. State regulations limit the recipient's right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

6. I understand that the disclosure of records or information may contain my photograph.

7. I understand that I have no obligation to permit disclosure of any records or information from my records. I may revoke this authorization, except to the extent that action has already been taken, at any time by mailing a written revocation letter to: Deputy Warden of Treatment Services, Bucks County Department of Corrections, 1730 South Easton Road, Doylestown, PA 18901. Absent an earlier revocation, this authorization will automatically expire 180 days after the date indicated below.

8. I understand that any records to be disclosed are the property of the Department of Corrections and that my authorization for their release does not require the Department of Corrections to release these records. This release does not supersede Federal Laws or Regulations that require confidentiality of records including those that bar secondary dissemination or re-disclosure.

9. I will indemnify and hold harmless the Bucks County Department of Corrections, the County of Bucks and its employees and agents, for any losses, costs, damages, or expenses incurred because of releasing information or records in accordance with this authorization.

10. By signing below, I acknowledge that I have read this form in its entirety and that I understand the nature of this release.

_____	_____	_____
Name (print)	Inmate #	Date of Birth
_____	_____	_____
Inmate Signature	Date	Signature of Witness