

**UNITED STATES PROBATION**  
**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**  
*(Drug or Alcohol Abuse Programs)*

I, \_\_\_\_\_  
(Name of Client)

The undersigned, hereby authorize \_\_\_\_\_  
(Name of Program)

To release confidential information in its records, possession, or knowledge, of whatever nature may now exist or come to exist to the United States Probation & Pretrial Services Office for the District of North Dakota.

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 the release is to be used in connection with my participation in the aforementioned program which has been made a condition of my supervision.

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:

\_\_\_\_\_  
(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 Client)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Signature of Parent or Guardian, if Client is a Minor)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Name & Title of Witness)

\_\_\_\_\_  
(Date Signed)