SUFFOLK DEFENDERS PROGRAM
tel 617.573.8100 fax 617.742.2139

SUFFOLK UNIVERSITY LAW SCHOOL

RELEASE OF MEDICAL INFORMATION

I, _____, authorize and permit _____ of the Suffolk Defenders at Suffolk University Law School and his or her approved representative (e.g. student attorney, investigator, supervising attorney or expert defense witness) to inspect and/or copy any and all documents and records pertaining to me which are in the custody or control of the entity or institution named below. This includes the release of my complete medical, mental health, educational, employment, and other institutional records, including, but not limited to any records of psychiatric examination, counseling, treatment for drug and/or alcohol abuse, or HIV/AIDS treatment, from any public or private entity at which the records are held.

By signing this form, I authorize the use and disclosure of my protected health information from _____, to the above named for the purpose of legal representation in my pending case in _____ Court, pursuant to my rights below and the HIPAA Standards of April 14, 2003 (see 45 CFR 164.508(c)). I authorize disclosure of (check one) ☐ all information; or ☐ only records relating to: _____.

I also authorize any medical or mental health professional from the above named institution to discuss any aspect of my treatment with my student attorney and any approved representative of the student attorney.

I release the above mentioned possessor and custodian of such information from any and all liability for its disclosure.

I understand that this release is effective beginning on the date it is signed and shall be effective for one year from that date or at the end of my representation by the Suffolk Defenders, which ever comes first, unless permission is withdrawn by me.

I understand that I may revoke this authorization at any time, but must do so in writing.

I understand that the information requested herein is for the sole benefit of assisting in my legal defense relating to pending criminal charges and may be re-disclosed by the Suffolk Defenders for that exclusive purpose.

I understand that the disclosed information, specifically if the records involve treatment for alcohol or substance addiction, may be privileged and/or confidential and are protected by both state and federal law, (see 42 C.F.R. Part 2).

A photocopy of this release is intended to have the same force and effect as the original.

_____	_____	_____
Signed	**Date**	**Date of Birth**
_____	_____	
Social Security Number	**Admission/Release Dates, if applicable**	