

CASE TRANSFER AND AUTHORIZATION TO RELEASE

I _____, Date of Birth: _____, understand that my attorney

_____ will be referring my case to another attorney who will be working with me during the period I am committed to DCF. I also understand that all of the information that my attorney has from my court cases will be shared with the new attorney at the Post Conviction Unit. I hereby authorize my present attorney to release and produce my entire file including all materials maintained that concern me and to discuss all of the contents with: The Juvenile Post Conviction Unit/Office of the Chief Public Defender, 30 Trinity Street, Hartford, CT, or **any** authorized representative from that office including other attorneys, investigators, paralegals and clerks. I am aware that the information and documents sought may be privileged, highly personal and contain very sensitive information, but is my intention to authorize and ask you to share them with the Juvenile Post Conviction Unit. I understand that if this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2 and Ch. 368x) prohibit the Juvenile Post Conviction Unit from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. State law contains similar provisions with respect of confidential HIV information, C.G.S. 19a -585. Although it is my intention that this authorization be as broad and comprehensive as possible and that it include materials and information I have not specifically set forth, I designate the following types of records, reports, diagnostic, treatment materials to be disclosed:

- ✓ HOSPITAL
- ✓ MEDICAL
- ✓ HEALTHCARE PROVIDER
- ✓ DOCTOR
- ✓ THERAPIST
- ✓ PSYCHIATRIC OR OTHER
- ✓ MENTAL HEALTH TREATMENT
- ✓ SUBSTANCE ABUSE TREATMENT

It is further my intention that all other documents requested by my attorneys at the Juvenile Post Conviction Unit be disclosed. It is my intention that this release be as broad and comprehensive as possible to permit my attorneys at the Juvenile Post Conviction Unit to better represent me. I further intend that a copy or facsimile transmission of this document will be as effective as an original. Thank you for your prompt cooperation with the requests of the above-mentioned office.

Notice to Individual Requesting the Disclosure: *Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.*

STATE OF CONNECTICUT }

} ss:

COUNTY OF }

_____, 2016

Subscribed and sworn to before me this _____ day of _____, 2016

Commissioner of the Superior Court
Public Defender Investigator/Paralegal
Notary Public, My Commission Expires: