SUPERVISED RELEASE PROGRAM
Authorization for Release of Information

TO: _____
Treatment Agency

_____
Address

_____
City State ZIP

FROM: Adams County Sheriff's Office
Supervised Release
4201 East 72nd Avenue, Suite B
Commerce City, CO 80022
720-322-1390

Please furnish information from the treatment agency or other record of:

Client's Name _____ DOB _____

Social Security Number _____ Court Case Number _____

Comments _____

_____

A PHOTOCOPY OF THIS REQUEST IS TO BE CONSIDERED AS VALID AS THE ORIGINAL

I hereby release the Board of County Commissioners of the County of Adams, State of Colorado, the Adams County Sheriff, and their employees and agents from all liability and all claims of any nature whatsoever pertaining to the disclosure of any information requested and received. I further waive any privilege of confidence of communication between myself and any therapist, counselor or others who have examined or treated me or who have possession of records relating to myself. The SPECIFIC purpose for which information is to be released is for the above court case ONLY.

Client's Signature _____ Date/Time _____

Witness' Signature _____ Date/Time _____

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

White: Other Yellow: File