

**UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF NEW YORK  
PROBATION AND PRETRIAL SERVICES**

**TIMOTHY C. ENGLERTH**

Chief Probation Officer

Robert H. Jackson United States Courthouse  
2 Niagara Square  
Buffalo, New York 14202-3350  
(716)551-4241  
(716)551-4988 fax

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Federal Building Room 1200  
100 State Street  
Rochester, New York 14614  
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**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

Name: \_\_\_\_\_ PACTS #: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Race/Sex: \_\_\_\_\_  
Address: \_\_\_\_\_  
Other Names including Maiden name: \_\_\_\_\_ Mother's Maiden name: \_\_\_\_\_

This documentation is to serve as my request for information as provided by the FREEDOM OF INFORMATION ACT and release of information as required by the PRIVACY ACT OF 1974. Having read the explanation of my rights, which is attached to this form, and having been convicted in the

U.S. District Court, in accordance with Rule 32(d)(2)(A) through (G) of the Federal Rules of Criminal Procedure and 18 U.S.C. §3664(D)(3), **by my signature below, I hereby authorize release to the United States Probation Office those confidential records and information pertaining to me for the purpose of assisting with court proceedings as designated below by my initials (items not initialed are considered surplusage):**

\_\_\_\_ Educational records and information contained in permanent school records pursuant to the provisions of 34 CFR 99.

\_\_\_\_ Medical records of a **physical health nature**, including (state nature of information) \_\_\_\_\_  
as administered by (state name/institution holding records) \_\_\_\_\_  
between the dates of \_\_\_\_\_ and \_\_\_\_\_ pursuant to the provisions of 5 U.S.C. §552a, 20 CFR 401 and 42 CFR 2.

\_\_\_\_ Medical records of a **psychological/psychiatric nature**, including (state nature of information) \_\_\_\_\_  
as administered by (state name/institution holding records) \_\_\_\_\_  
between the dates of \_\_\_\_\_ and \_\_\_\_\_ pursuant to the provisions of 5 U.S.C. §552a, 20 CFR 401 and 42 CFR 2.

\_\_\_\_ Medical records of a **alcohol/drug treatment nature**, including (state nature of information) \_\_\_\_\_  
as administered by (state name/institution holding records) \_\_\_\_\_  
between the dates of \_\_\_\_\_ and \_\_\_\_\_ pursuant to the provisions of 5 U.S.C. §552a, 20 CFR 401 and 42 CFR 2.

\_\_\_\_ Employment records including but not limited to dates of employment, salary and compensation, work performance and reason for termination.

\_\_\_\_ All government (federal, state and local) information including but not limited to court records, military service records, birth/marriage/divorce records, child support records, and immigration and naturalization records. I also authorize the Social Security Administration to release all employment earnings and income information related to me as well as any benefit/disability information.

\_\_\_\_ Financial records including but not limited to charge accounts, loans, bank accounts, securities, real estate, life insurance, motor vehicles, lines of credit (including credit bureau reports), trusts and any other assets or liabilities in which I have interest.

**APPLICABLE TO ALL RECORD AUTHORIZATIONS: Original authorizations, or copies, will remain in force for a period not to exceed one (1) year from the date of my signature below. I understand that I may revoke the authorization of release of records at any time. Revocation of this authorization requires a written request submitted by me to the individual/institution holding/disseminating records. I understand that any action taken on this authorization prior to the rescinded date is legal and binding and that this document releases all participants from liability in the product or release of information. I also understand that the health information may include that which relates to sexually transmitted diseases, AIDS, HIV, mental health services, and/or treatment for alcohol and drug abuse.**

**NOTE: The individual authorizing disclosure of information permits the use of photostatic and tele-faxed copies of this release in lieu of the original. The U.S. Probation Office is not able to provide reimbursement for photocopies submitted by agencies in response to any requests for information.**

\_\_\_\_\_  
Signature of Person Authorizing Disclosure (and relationship if not the subject of records) \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Witness / United States Probation Officer \_\_\_\_\_ Date \_\_\_\_\_

←----- Initial Each Line -----→