



**DIVISION OF PUBLIC DEFENDER SERVICES**  
**State of Connecticut**

I, \_\_\_\_\_ D.O.B. \_\_\_\_\_ hereby give permission to my Attorney, \_\_\_\_\_ to disclose the contents of my case file including the confidential medical, educational and psychiatric records in his/her possession to (the) \_\_\_\_\_.

I also expressly consent to give my Attorneys in \_\_\_\_\_ and \_\_\_\_\_; and their authorized agents the authority to discuss my pending criminal matters with each office for the purpose of my legal defense. (This consent also includes communication through email or facsimile). This consent if not withdrawn, will automatically expire according to the following specification: upon disposition of case(s).

**Release of Information Relating to an HIV Diagnosis**

I may withdraw this consent at any time prior to the release of pertinent medical and/or psychiatric information relevant to a diagnosis to HIV.

This information has been disclosed to you from records whose confidentiality is protected by state law. A general authorization for the release of medical or other information is not sufficient for this purpose. C.G.S. 19a-565

Client: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_