



U.S. Department of Justice

Federal Bureau of Prisons

Federal Correctional Institution

PO Box 1000
Butner NC 27509-1000

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Inmate Name: F
Date of Birth: 06/09/76

SS#:
BOP Reg.

To: Mille Lacs Academy

100 Crosier Drive North, Suite J
Oramoa, Minnesota 56359 (320) 532-4005

Laurie
ext 509

DATES OF TREATMENT: April - October 1992 (Files destroyed in 2003)
I request and authorize the Mille Lacs Academy to release the information specified below to the organization, agency, or individual named on this request. I understand that the information to be released includes information regarding the following:

- Complete Psychological Records including assessment data, reports, discharge summary
- Substance Abuse Treatment Records
- Complete Psychiatric Record including admission and discharge summaries
- Other - Specify: sex-offender treatment summary

PURPOSE FOR WHICH THE INFORMATION IS TO BE USED: Information is to be used for the purpose of evaluation, treatment, and release planning at the Sex Offender Treatment Program at the Federal Correctional Institution in Butner, North Carolina.

The above records are to be sent to:

M. Lela Demby, Ph.D.
Sexual Offender Treatment Program
Federal Correctional Institution
P.O. Box 1000
Butner, North Carolina 27509-1000

phone: (919) 575-4541 ext. 3652
fax: (919) 575-2017

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Rediscovery of my records by those receiving the above authorized information for purposes other than that stated above, is not permitted without my further written consent. Without my express revocation, this consent will automatically expire within one (1) year from the date of this Consent

SIGNATURE OF CLIENT: _____ DATE: 11-21-05

WITNESS' SIGNATURE: M. Lela Demby Ph.D. DATE: 11/21/05



UNITED STATES GOVERNMENT
Federal Bureau of Prisons
Federal Correctional Complex - Butner

**Polygraph Examination
Informed Consent Form**

I hereby consent to be interviewed and submit to a polygraph examination in connection with a psychosexual evaluation. I give consent of my own free will, voluntarily and without duress, threats, or promises. I understand that I do not have to take the polygraph examination, and that even after consenting to do so, I may stop the examination at any time.

I understand that the questions to be asked on this test will be reviewed with me prior to the examination.

I know of no physical problem which would impair my ability to be examined by polygraph.

The limits of confidentiality have been explained to me.

I understand that the examination room contains a recording device, specifically, a videotape camera. I understand that the audio and visual recordings are used for clinical purposes and may be used for quality control purposes. In the case of quality control, my name and Register Number will not be revealed.

I understand that the examiner uses videotaped segments of polygraph examinations to train other professionals.

 SM I give consent for the audiotape and/or videotape recording of my polygraph session(s) to be used for training purposes.

 I do **NOT** give consent for the audiotape and/or videotape recording of my polygraph session(s) to be used for training purposes.

 SM
Name (please print)

Register Number

 SM
Inmate Signature

 2-27-06
Date Time

**UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MENTAL HEALTH TREATMENT PROGRAMS**

I, _____, the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)

information in its possession to the United States Probation Office in the _____
(Name of Court)

The confidential information to be released will include: date of entrance to program; attendance records; drug detection test results; type, frequency, and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (e.g., psychological, psycho-physiological measurements, vocational, sex offense specific evaluations, clinical polygraphs); date of and reason for withdrawal or termination from program; diagnosis; and prognosis.

This information is to be used in connection with my participation in the above-mentioned program, which has been made a condition of my post-conviction supervision (including probation, parole, mandatory release, supervised release, or conditional release), and may be used by the probation officer for the purpose of keeping the probation officer informed concerning compliance with any condition or special condition of my supervision. I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

(Signature of Parent or Guardian (if Client is a Minor))

(Signature of Client)

(Date Signed)

(Date Signed)

(Name & Title of Witness)

(Date Signed)