Date	08/26/2022

Organization	U.S. Probation
District	Minnesota

Officer		
Name		
Name (separated)		
Position	U.S. Probation Officer	
Address		
Street Address	300 South 4th Street, Suite 406	
City	Minneapolis	
State	MN	
Zip	55443	
Phone		
Fax	612-664-5350	
Email		

Defendant/Offender			
PACTS #			
Name			
Name (separated)			
Date of Birth			
SSN			
Address			
Street Address			
City			
State			
Zip			
Phone			
OID #			

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
PROBATION AND PRETRIAL SERVICES OFFICE

KITO J. BESS
Chief Probation Officer
300 S 4th St., Ste. 406
Minneapolis MN 55415-1320
612-664-5400
FAX 612-664-5350

316 N Robert St., Ste. 600
St. Paul MN 55101-1465
651-848-1250
FAX 651-848-1255

515 W 1st St., Ste. 206
Duluth MN 55802-1302
218-529-3545
FAX 218-529-3546

619 Beltrami Ave. NW, Ste 100
Bemidji MN 56601-3066
218-210-6030
FAX 218-333-8055

118 S Mill St., Ste. 304
Fergus Falls MN 56537-2576
218-739-0041
FAX 218-739-0043

Reply to: Minneapolis 08/26/2022

Sherburne County Jail
13880 Business Center Drive NW
Elk River, MN 55330

REQUEST FOR MEDICAL RECORDS

RE:

Date of Birth:

TO WHOM IT MAY CONCERN:

The person identified above is under court-ordered investigation by this office, and the information requested is needed to complete this investigation. Your cooperation is greatly appreciated.

The defendant has received medical services at your facility. Please provide a summary of their medical concerns since their incarceration and a list of their medications. It is preferred that responses be e-mailed to me, though they can also be faxed or mailed. My contact information is listed below.

Sincerely,

s/

U.S. Probation Officer

Email:
Phone:
Fax: 612-664-5350

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
PROBATION AND PRETRIAL SERVICES OFFICE

KITO J. BESS
Chief Probation Officer
300 S 4th St., Ste. 406
Minneapolis MN 55415-1320
612-664-5400
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FAX 218-333-8055

118 S Mill St., Ste. 304
Fergus Falls MN 56537-2576
218-739-0041
FAX 218-739-0043

Reply to: Minneapolis 08/26/2022

Minnesota Department of Corrections

REQUEST FOR RECORDS

RE:
Alias:
DOB:
OID#:

The person identified above is under investigation by this office. The information requested below is needed to complete our investigation. Your immediate cooperation is greatly appreciated.

Specifically, I am looking for disciplinary reports, drug treatment records, any/all charging documents, institutional misconduct, programming for education/MI/CD/anger management, supervised release dates, supervised release violations, HRU dispositions, and discharge dates.

It is preferred that responses be e-mailed to me. However, you may fax or mail to the address listed above. If you have any questions, please call me. Thank you for your assistance.

Sincerely,

s/

U.S. Probation Officer

Email:
Phone:
Fax: 612-664-5350

Attached: Release Forms

PROB 11G
(Rev. 5/03)

AUTHORIZATION TO RELEASE INFORMATION
(PRIVATE PERSON OR ORGANIZATION)
TO PROBATION OFFICER

TO WHOM IT MAY CONCERN:

I, _____, the undersigned, hereby authorize the United States Probation Office for the _____ District of Minnesota, or its authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

- ☑ Employment
- ☑ Education Records (including, but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)
- ☐ Medical Records
- ☐ Psychological and Psychiatric Records

I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the United States Probation Office's official use.

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency; any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, 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.

Regarding protected health information, 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)

Regarding protected health information, 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.

✓		08/26/2022
(Authorizing Signature - Full Name)	(Full Name - Printed or Typed)	(Date)
WITNESS —		08/26/2022
	(Probation Officer)	(Date)

PROB 11G
(Rev. 5/03)

AUTHORIZATION TO RELEASE INFORMATION
(PRIVATE PERSON OR ORGANIZATION)
TO PROBATION OFFICER

TO WHOM IT MAY CONCERN:

I, _____, the undersigned, hereby authorize the United States Probation Office for the _____ District of Minnesota, or its authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

- ☐ Employment
- ☐ Education Records (including, but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)
- ☑ Medical Records
- ☑ Psychological and Psychiatric Records

I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the United States Probation Office's official use.

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency; any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, 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.

Regarding protected health information, 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:

Sherburne County Jail, 13880 Business Center Dr NW, Elk River, MN 55330.
(Name and Address of Program)

Regarding protected health information, 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.

(Authorizing Signature - Full Name)	(Full Name - Printed or Typed)	08/26/2022 (Date)
WITNESS —	_____ (Probation Officer)	08/26/2022 (Date)

Print patient's legal name _____ *(office use only: MR#* _____ *)*
Previous names_____ Birth date _____ Social Security # _____ *(optional)*
Phone numbers (Home)_____ (Work)_____ (Other) _____

1. Please release my records from: *(Who has your records?)*
Clinic or organization (if not printed above): _____
Address: _____ City: _____
State:_____ Zip code: _____ Phone: _____ Fax:_____

2. Please release my records to: *(Who needs your records?)*
Person, clinic or organization (if not printed above): _____
Address: 300 South 4th Street, Suite 406 City: Minneapolis
State: MN Zip code: 55443 Phone: _____ Fax: 612-664-5350
If releasing records to yourself, should the envelope be marked "Personal and Confidential"? ☐ *Yes* ☐ *No*

3. These are the records I would like to release: ☐ **All pertinent records,** or check all that apply below

☐ Discharge summary	☐ Pathology reports	☐ EKG/ECHO reports
☐ Counselor's discharge summary	☐ Lab reports	☐ Emergency or urgent care reports
☐ History and physical exam	☐ X-ray / Radiology reports	☐ Psychological tests
☐ Consultation reports	☐ Films / CDs	☐ ***For MD only:*** Pathology slides / tissue blocks
☐ Outpatient clinic notes	☐ Operative reports	☐ Other: _____

For condition or dates of treatment: _____ *(If blank, we will release 1 year's worth of most recent records.)*
Date records are needed by: _____. *Will records be picked up?* ☐ *Yes* ☒ *No*

4. Purpose:

☐ Continued care by another provider	☐ Insurance claim	☐ Personal use
☐ Social Security disability	☐ Attorney review	☒ Other court-ordered report

5. I understand the following:

- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the person, clinic or organization named above. This includes details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV.
  If I don't want these to be released, I will place a check mark here: _____. I do not want the following records released: _____.
- If I change my mind, I may write to the address in section 1 to stop the release of my records. This will not apply to records that have already been released.
- This form expires one year after I sign it or sooner (specify here: _____).
  The time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing these records.
- Once the records are released to the person, clinic or organization named above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless treatment is part of a research project.

08/26/2022 _____ _____
Date/Time *Signature of patient or authorized person* *Authorized person's authority to sign (proof required)*
Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other: _____

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth _____ _____ Previous name(s) _____
MM DD YYYY

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name U.S. Probation

And/or person: First name _____ Last name _____

Mailing address 300 South 4th Street, Suite 406

City Minneapolis State MN Zip code 55443

Phone (optional) _____ Fax (optional) 612-664-5350

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☒ Chemical dependency program *(see definition in instructions)*

☒ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☒ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☒ Other (please explain) court-ordered report

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date 08/26/2022
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ / ___ / _____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

PROB 11E
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PROGRAMS

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

hereby authorize _____ to release confidential
(Name of Program)

information in its records, possession, or knowledge of whatever nature may now exist or come to exist to the United States Probation Office of the _____ District of Minnesota .
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing 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 (psychological, vocational, etc.); psychotherapy notes; date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with the preparation of a court-ordered report.

I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court.

I understand that this authorization is valid until I have been sentenced and my sentence is final, 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 the completion of the presentence investigation will be reported to the court.

_____	
(Signature of Parent or Guardian if Client is a Minor)	(Signature of Client)
	08/26/2022
(Date Signed)	(Date Signed)
USPO	08/26/2022
(Name & Title of Witness)	(Date Signed)

PROB 11H
(Rev. 5/03)

PACTS # _____

AUTHORIZATION
TO RELEASE GOVERNMENT (STATE OR FEDERAL) INFORMATION
TO PROBATION OFFICER

I, _____, the undersigned,

hereby my rights under the Privacy Act, 5 U.S.C. 552a (Supp. IV, 1974), and authorize the disclosure to the

United States Probation Office of the District of Minnesota

or its authorized representative(s) or employee(s), any and all information pertaining to me, contained in the files or systems of records maintained by any government agency subject to the Privacy Act, which such agency sees fit to convey, either orally or in writing, to the aforementioned Probation Office.

I hereby waive any rights I may have under the Privacy Act to prior notice of such disclosure, or of any rights I may have to an accounting of such disclosure to the aforementioned Probation Office.

I understand that this authorization will be used by the aforementioned Probation Office to request disclosure of information pertaining to me from any or all federal or state agencies.

This information is to be obtained for the purpose of conducting a presentence investigation and making a report or for supervision.

Regarding protected health information, 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.

Regarding protected health information, 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)

Regarding protected health information, 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 this information 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.

✓ _____
Authorizing Signature (full name)

_____ 08/26/2022
Full Name (printed or typed) Date

_____
Parent/Guardian Signature, if Required

_____
Attorney Signature, if Available

WITNESS —

_____ 08/26/2022
Probation Officer Date

DEPARTMENT OF CORRECTIONS

Authorization for Release of Information

I, _____ authorize Minnesota Department of Corrections
(name) (agency to release information)

to release data about me to the following individual(s):

Name:	
Title:	U.S. Probation Officer
Address:	300 South 4th Street, Suite 406 Minneapolis MN 55443
List and describe all data covered by this release:	any/all charging documents, institutional misconduct, programming for education/MI/CD/anger management, supervised release dates, supervised release violations, HRU dispositions, and discharge dates

I understand:

- the data listed above may include data classified as private under Minn. Stat. Ch. 13 and otherwise only accessible to me, the Minnesota Department of Corrections (DOC), or anyone authorized by law to receive it.
- by signing this form, I authorize the DOC to release data to the person(s) named.
- the DOC cannot release data classified as private without my authorization.
- the DOC cannot control how the person receiving the released data about me uses it.

I am signing this consent form voluntarily and understand the consequences of signing. This consent expires after completion of the above-stated purpose or after one year, whichever comes first, unless I choose to renew this consent.

08/26/2022
Date

Signature of Subject of Data

Signature of Parent/Guardian/Authorized Representative (if the subject of the data is a juvenile)

Revised 3/29/18

Minnesota Department of Corrections

Authorization to Release Information

HIPAA Notice to Offender, Provider, or Covered Entity

- This release is provided in compliance with Minn. Stat. § 144.293.
- Correctional institutions, including the Minnesota Department of Corrections, are exempt from many of the privacy regulations of HIPAA.
  - "A covered entity may disclose to a correctional institution . . . having lawful custody of an inmate or other individual protected health information about such inmate or individual [without written authorization or the opportunity for the individual to agree or object] if the correctional institution represents that such protected health information is necessary for the provision of health care to such individuals," the health and safety of other inmate or employees, law enforcement, or facility order and security. 45 CFR 164.512 (j)(5).
  - Notice of Privacy Practices is not required to be given to inmates. 45 CFR 164.520 (a)(3)
  - The right to an accounting for disclosures of protected health information does not include disclosures to correctional institutions. 45 CFR 164.528 (a)(1)(vii)
- This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Name: _____

OID # _____ Date of Birth: _____

Other Names Used: _____

I hereby authorize:

Minnesota Department of Corrections –
Central Office Records Management

Phone: 651-361-7338
Fax: 651-643-3588

To release the following information to:

300 South 4th Street, Suite 406
Minneapolis MN 55443

(phone) (fax) 612-664-5350

The following information is to be released

☐ Discharge summary	☐ Progress notes	☐ Operative report	☒ Psychological testing
☐ History & physical	☐ Lab report	☐ Imaging report	☒ Mental health assessments
☐ Consultation report	☐ EKG/EEG report	☐ Outpatient/ER report	☒ Mental health treatment summaries
☐ Pathology report	☐ Other: _____		

Related to the following time period and/or condition: _____

For the following purpose(s)

☐ Continued health care ☐ Release planning
☐ Litigation ☐ Personal use
☒ Other: court-ordered report

This Authorization Expires one year from the date of signature unless otherwise specified below:

Expiration date or event: _____

- Records pertaining to mental health, chemical dependency, or HIV/AIDS may be released unless otherwise indicated by my initials here:_____
- I understand there may be a retrieval and copy charge for this information.
- I am not required to sign this form to receive health care services from the Department of Corrections, but I understand that my failure to do so could adversely affect my care, due to incomplete history or other information; or any proceeding for which it was requested.
- I may revoke this consent at any time by providing notice in writing, and I understand that this revocation will not effect any actions the entity took before the revocation was received.
- The information disclosed under authority of this authorization may be re-released by the receiving entity in accord with federal and state law.

_____ 08/26/2022

Signature of patient (or authorized representative) Date

_____

Printed name of representative & their authority to sign for the patient

Minnesota Department of Human Services

DHS-5510-ENG 12-14

Authorization for Release of Child Support Information to a Third Party

Date: 08/26/2022

Re:

CLIENT NAME (Print)	MCI NUMBER

Purpose: I give permission to a third party to discuss my child support case with the Child Support Division of the Minnesota Department of Human Services (DHS) and the _____ _____ County child support office(s). I authorize DHS and the county child support office(s) to release private information regarding my child support case to a third party.

This is a:

☐ **Full release –** These agencies may release all of the private information in my child support file that would be available to me. I understand that this may include data on payment information, arrears, interest, employer information, wage information, medical insurance or assistance, public assistance, and other private data about me.

☐ **Partial release –** These agencies may release only the following type(s) of private information.

_____

_____

_____

This information may be released to the following person(s) or agencies/entities:

U.S. Probation	

Authorization for Release of Information

Giving Permission: I give permission for DHS and the county child support office to discuss private information concerning my child support case with the person or entity/agency listed above who would not otherwise be entitled to the information. This information is used to allow a third party access to assist in resolving any issues involving my child support case. I understand that I am not required to have a third party look at my case.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to share/release this information
- I do not have to consent to this authorization, but it may affect my child support services if I do not give my consent
- If I am releasing information to an elected official, staff members of the elected official may review this information
- Generally, I must give my written consent for the listed agencies to give out my private information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agencies have already shared/requested
- The person or agency/entity who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE ✓	DATE 08/26/2022	Original copy for agency Provide copy to client

PROB 11A
(9/77)

UNITED STATES DISTRICT COURT
FEDERAL PROBATION SYSTEM

AUTHORIZATION TO RELEASE CONFIDENTIAL MILITARY INFORMATION

NAME (Last, First, Middle)	DATE OF BIRTH	DATE SIGNED
		08/26/2022

The above named individual is a defendant before the U.S. District Court for the _____

District of Minnesota

The requested documents are necessary to complete an official report ordered by this court.

I authorize release to the United States probation office all confidential records and information concerning me, including any information contained in a system of records of a government agency or other agencies and facilities subject to the Privacy Act or similar restrictions.

This authorization shall remain in effect until it is revoked in writing.

(Signature of Defendant) — 08/26/2022 (Date)

WITNESS: _____
(Signature of Probation Officer) — 08/26/2022 (Date)

AUTHORIZATION FOR RELEASE OF MILITARY MEDICAL PATIENT RECORDS (Drug Rehabilitation)

The National Personnel Records Center, General Services Administration, is hereby authorized to release copies of my military medical treatment records as described below.

NAME OF PERSON AUTHORIZED TO RECEIVE RECORDS

NAME AND ADDRESS OF FACILITY TO RECEIVE RECORDS

U.S. Probation 300 South 4th Street, Suite 406 Minneapolis MN 55443

PLACE WHERE TREATMENT OCCURRED	APPROXIMATE PERIOD OF TREATMENT

SPECIFIC TYPE OF TREATMENT INVOLVED

PURPOSE FOR WHICH RECORDS ARE NEEDED

THIS AUTHORIZATION EXPIRES WITHOUT EXPRESS REVOCATION 12 MONTHS FROM THE FOLLOWING DATE.

DATE	SIGNATURE OF INDIVIDUAL WHOSE RECORDS ARE REQUESTED
	

PROB 48E
(Rev. 07/13)

CUSTOMER CONSENT AND AUTHORIZATION FOR ACCESS TO FINANCIAL RECORDS FOR PRESENTENCE REPORT

I, _____ , having read the explanation
(Name of Customer)
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)(ii) (and 18 U.S.C. § 3664(d)(3) when restitution may be imposed), hereby authorize the

Equifax
(Name and Address of Financial Institution or Credit Agency)

to disclose the following financial records:
credit report

to _____ , an officer of the
(Name of Probation Officer Allowed Access)
U.S. District Court for the District of Minnesota ,
(Name of District Court)
to obtain information on assets I own or control, fully describing my financial resources to the United States probation officer for the purpose of preparing a presentence investigation report.

I understand that this authorization may be revoked by me in writing at any time before my records, as described above, are disclosed and that this authorization is valid for no more than three (3) months from the date of my signature. I understand further that my authorization cannot be required as a condition of my doing business with the above-named financial institution.

08/26/2022
(Date)

_____
(Signature of Customer)

_____ _____
(Social Security Number of Customer) *(Date of Birth of Customer)*

_____
(Address of Customer)

_____
(City/State/Zip Code)

Section 1104(a) of the Right to Financial Privacy Act, 12 U.S.C. § 3404(a).

PROB 74
(9/99)

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

INFORMATION RELEASED BY:	INFORMATION RELEASED TO:
Name	Name
Organization	Organization U.S. Probation
Address	Address 300 South 4th Street, Suite 406
City, State, Zip Code	City, State, Zip Code Minneapolis MN 55443

SUBJECT OF RECORD

Name	Date of Birth
Address	Identifying Number
City, State, Zip Code	

Specific Records Authorized for Release (Include dates of records, if applicable.)

Purpose or Need for Release of Information (Be specific.) court-ordered report

I understand that I may revoke this authorization in writing at any time, except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initialed below.

☐ Authorization expires as of _____ .

☒ Authorization expires _____ month(s) from signature date.

☐ Authorization expires _____ month(s) from signature date.

As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) as specified above.

Signature of Subject of Record	Date
✓	08/26/2022
Signature of Other Legally Authorized Person (if applicable)	Date

Relationship to Subject of Record