



Seward County Pretrial Diversion

SEWARD COUNTY PRETRIAL DIVERSION

Serving Adults and Youth in Seward County

AUTHORIZATION TO RECEIVE/RELEASE OF INFORMATION

CLIENT IDENTIFICATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Seward County Pretrial Diversion to

receive  and/or release  information to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

The information to be provided shall include the following:

- Prior or current treatment
 Evaluations/Assessments
 Criminal History
 Education Records
 Psychological Evaluations
 Other \_\_\_\_\_

The purpose for which the information is to be received/released is for participation in the Seward County Pretrial Diversion Program.

This authorization to release information will be effective for one (1) year from the date of this release. This authorization is not to exceed 30 days from discharge. I further understand that I may revoke this authorization in writing at any time except to the extent that the program, agency, or person requested to release the above information has previously acted in reliance upon it. This information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I hereby release Seward County Pretrial Diversion Program from all legal liability that might arise from the acceptance or disclosure of information requested above.

I consider a photocopy of this authorization to be as valid as the original.

I have read and received a photocopy of this document.

Signature of Client

Date

Parent Signature (if client is a minor)

Date

Pretrial Diversion Representative

Date