



Iowa Department of Corrections

KIM REYNOLDS, GOVERNOR
CHRIS COURNOYER, LT. GOVERNOR

BETH SKINNER, PHD, DIRECTOR
DARIN COX, 5TH DISTRICT DIRECTOR

The Court has ordered our department to complete a pre-sentence investigation in your criminal case. Even if you have waived the use of a pre-sentence report for sentencing purposes, state law requires that a pre-sentence investigation be completed.

If you are out of custody, you have TWO (2) DAYS to contact the Pre-Sentence Investigation Office. Please call **(515) 242-6602** to schedule your pre-sentence interview. Please THOROUGHLY complete the attached PSI data form **IN BLACK INK**, answering each question completely and to the best of your knowledge. Use **“NA”** for questions that do not apply to you rather than leaving them blank.

There are also **TWO** releases of information attached that require **THREE** signatures from you. This will allow us to verify the information we gather during the PSI interview.

IF YOU ARE IN JAIL CUSTODY and have not been sentenced, you are responsible for completing this packet. **PLEASE DO THIS TODAY AND TURN IT INTO JAIL STAFF.**

Thank you for your Cooperation,

Presentence Investigation Unit

Mission Statement:

We protect the public, employees, and offenders from victimization, and we seek to help transform offenders into productive and responsible Iowa citizens.

<https://doc.iowa.gov/>

PSI BIO FORM (USE BLACK INK)

PSI Writer _____ Date _____

Full Legal Name _____ Male Female

Birth name (if different) _____

Other Names Used _____

Social Security Number _____ Date of Birth _____

Place of Birth _____ Date that you entered the US _____

Illegal alien Yes No Alien Resident Yes No

Height _____ Weight _____ Eyes _____ Hair _____ Race _____

Tattoos - Locations and Descriptions

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Marks and Scars - Locations

1.) _____ 3.) _____

2.) _____ 4.) _____

Piercing(s) - Locations

1.) _____ 2.) _____ 3.) _____

CRIMINAL HISTORY

Co-defendant(s) in this case _____

Date of Arrest _____ Date of Release _____

Who posted your bond? _____

Were you on probation or parole at the time of this arrest? Yes No

If yes, who was your supervising officer? _____

Describe your relationship with your probation/parole officer _____

JUVENILE

List all crimes you were charged with as a juvenile (under the age of 18) _____

What county and state? _____

Age at the time of first charge? _____

Were you ever placed on juvenile probation? Yes No

Were you placed in a group home or correctional facility? Yes No

If yes, name and location? _____

ADULT

Have you ever been arrested OUTSIDE of the state of Iowa? Yes No

List below

Charge	Place	Date	Sentence
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been sentenced to jail, prison, or a residential facility outside of the State of Iowa? Yes No

If yes, when and where? _____

Have you ever escaped or attempted to escape from a youth or adult correctional or residential facility outside of the State of Iowa? Yes No

If yes, when and where? _____

Are you required to register as a Sex Offender? Yes No

What is the status of your driver's license? _____

In what state was your last driver's license issued? _____

EMPLOYMENT (Bring a current pay stub, must be verified)

If you are NOT employed, which of the following applies?

Unemployed Disabled Retired Laid off Start Date of this Status _____

Current Employer Name and Address _____

Occupation _____ Start Date _____

Rate of Pay _____ How many hours a week do you work? _____

Supervisor _____ Phone _____

Is your supervisor aware of these charges and what did they say about them? Yes No

How would your supervisor rate your performance? _____

How well do you like your job and how long do you intend to work there? _____

Previous Employer Name and Address _____

Occupation _____ Start Date _____ End Date _____

Rate of Pay _____ Number of hours worked per week _____

Reason for Leaving? _____

Previous Employer Name and Address _____

Occupation _____ Start Date _____ End Date _____

Rate of Pay _____ Number of hours worked per week _____

Reason for Leaving? _____

Have you ever been fired or quit without notice? Yes No If so, why? _____

Have you ever reported for work high, drunk or hung over? Yes No

What problems have you had with co-workers or supervisors? _____

How do you react when you are given a task on the job? _____

Have you ever violated work rules and why? _____

What are your career goals and what steps have you taken to achieve these goals? _____

MILITARY RECORDS

Have you ever served in the United States Armed Forces? Yes No

Branch of Service _____ Type of Discharge _____

Occupation _____ Start Date _____ End Date _____

Are you eligible for VA benefits? Yes No

Have you experienced trauma as a result of deployment? Yes No

EDUCATION

Last High School Attended and Location _____

What year did you graduate? _____

If not, what is the highest grade completed? _____

Reason for leaving school _____

Were you ever suspended? Yes No Were you ever expelled? Yes No

If yes, why? _____

Have you been diagnosed with a learning difficulty in school? Yes No

ADD ADHD Dyslexia Other _____

Age of Diagnosis _____ Medication(s) Prescribed _____

Were you placed in Special Education, Resource, or Behavior Disorder classes? Yes No

If yes, specify _____

Do you have difficulty reading or writing English? Yes No

If GED, Issued by _____ State and County _____ When? _____

Colleges attended (include degrees, certifications, and licenses) _____

What are your educational goals and what steps are you taking to achieve these goals? _____

FINANCIAL

Including all sources, what was your total income for last year? \$ _____

Was any of this income a result of illegal activities (i.e. theft, selling drugs, etc.)? Yes No

Do you pay your bills on time? Yes No

Do you have an active savings and/or checking account? Yes No

Have you ever declared bankruptcy or been advised to do so? Yes No

Do you worry about having enough money to meet your needs? Yes No

Have your wages ever been garnished? Yes No

Why? _____

Are you ordered to pay child support? Yes No What State? _____

If yes, how much per month? \$ _____ Amount Behind? _____

Have you or anyone in your household received any type of financial assistance in the last year? Yes No

*If yes, circle those that apply (Food Stamps, FIP, WIC, Medical Benefits, Unemployment, Disability, Worker's Compensation, Housing Assistance)

How often do you gamble? _____

Has gambling ever been a problem for you? Yes No

If yes, explain _____

DEBT INFORMATION

List your total debts and amount owed for each (exclude court obligations i.e. fines, restitution, court costs)

ASSET INFORMATION

List each of your assets and their worth \$ _____

FAMILY

Are you adopted? Yes No

BIOLOGICAL/ADOPTED FATHER Living Deceased

Name _____ Date of birth _____

Address _____ Phone Number _____

Employment _____

Does he have a history of alcohol or drug abuse? Yes No

Does he have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your father _____

STEPFATHER Living Deceased

Name _____ Date of birth _____

Address _____ Phone Number _____

Employment _____

Does he have a history of alcohol or drug abuse? Yes NoDoes he have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your adopted or stepfather _____

BIOLOGICAL/ADOPTED MOTHER Living Deceased

Name _____ Date of birth _____

Maiden Name _____ Phone Number _____

Address _____

Employment _____

Does she have a history of alcohol or drug abuse? Yes NoDoes she have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your mother _____

STEPMOTHER Living Deceased

Name _____ Date of birth _____

Maiden Name _____ Phone Number _____

Address _____

Employment _____

Does she have a history of alcohol or drug abuse? Yes NoDoes she have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your adopted or stepmother _____

BROTHERS AND SISTERS (Please List All)

Name _____ Date of birth _____

Address _____

Phone Number _____ Employment _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Name _____ Date of birth _____

Address _____

Phone Number _____ Employment _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Name _____ Date of birth _____

Address _____

Phone Number _____ Employment _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Name _____ Date of birth _____

Address _____

Phone Number _____ Occupation _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Provide a brief overview of your childhood. (Living conditions, discipline, family life) _____

Did you have adequate food, clothing, and shelter during your childhood? Yes No

If no, explain _____

Were you ever physically, emotionally, verbally or sexually abused as a child? Yes No

If yes, explain _____

Have any of your immediate family members been diagnosed with a mental health Yes No

condition? If so, explain _____

Who makes up your support system and how do they assist you? _____

What does your family say to you about your legal trouble and how has it changed your family relationships? _____

MARITAL

Are you currently in a relationship? Yes No Length of this relationship _____

Type of Relationship Marriage Common Law Long Term Dating

Your current partner's name (spouse or significant other) _____

Date of Birth _____ Partner's Maiden Name _____

Address _____

Date of Marriage _____ Telephone Number _____

Occupation _____ Employer _____

Is your partner involved in this offense? Yes No

Does your partner have a criminal history? Yes No

Explain _____

Has your partner ever abused alcohol or drugs? Yes No

Do you feel you are in a good relationship? Yes No

Does your partner put you down or make unreasonable demands on you? Yes No

How has your legal trouble affected your relationship? _____

What would make your relationship better? _____

What do you and your partner argue about most? _____

How do you solve disagreements in the relationship? _____

Have fights with your partner ever gotten physical? Yes No

Have you ever been physically, verbally, emotionally, or sexual abused by a partner? Yes No

If yes, please explain _____

PRIOR RELATIONSHIP

Type of relationship Marriage Common law Long term Dating

Name of partner _____ Length of relationship _____

When did the relationship end and why? _____

Were there domestic incidents? Yes No

PRIOR RELATIONSHIP

Type of relationship Marriage Common law Long term Dating

Name of partner _____ Length of relationship _____

When did the relationship end and why? _____

Were there domestic incidents? Yes No

CHILDREN

Name _____ Date Of Birth _____ Male Female

Address _____

Phone number _____ Other parent _____

Who does your child live with? _____

Describe your relationship and level of contact with your child _____

Who does your child live with? _____

Describe your relationship and level of contact with your child _____

Who does your child live with? _____

Describe your relationship and level of contact with your child _____

Who does your child live with? _____

Describe your relationship and level of contact with your child. _____

Yes No

Yes No

Yes No

Yes No

RESIDENTIAL HISTORY

Current address (OR your address at the time of your arrest if you are currently in jail)

Start Date _____ Phone _____ Email _____

Living with? _____ Monthly rent or mortgage \$ _____

Do you plan to return to this address following sentencing? Yes No

If not, where will you live (include street, city, and state)? _____

Describe your neighborhood (i.e., quiet, middle class, high police presence, frequent raids, gang activity, drug activity, etc.)

Do you feel safe at this home? Yes No

How long do you see yourself living here? _____

Is anyone living at this address using drugs and/or alcohol? Yes No

Is anyone living at this address on probation or parole? Yes No

Previous address _____

Start date _____ End date _____

Who did you live with? _____

Previous address _____

Start date _____ End date _____

Who did you live with? _____

Other states of residence _____

LEISURE/RECREATION

What community organizations have you participated in over the last year and what is your level of involvement? _____

What things do you do in a typical day? _____

How have your activities changed since your arrest? _____

COMPANIONS

Describe the people you were associating with prior to your arrest _____

Have your peer relationships changed since your arrest? If so, how? _____

Do you spend time with friends who have no substance abuse or criminal history? Yes No

How do you spend your time together? _____

Do you consider yourself a loner? Yes No

Do you find it difficult confiding in others? Yes No

Do you find it difficult to trust others? Yes No

Have you ever been affiliated with or a member of a gang? Yes No

If so, which one and for how long? _____

ALCOHOL/DRUG PROBLEMS

Age of first alcohol use _____ Date of last alcohol use _____

In the last year, how many times a week did you consume alcohol? _____

How many drinks did you consume each time? _____

Do you feel you currently have an alcohol problem? Yes No

Do you feel you have had an alcohol problem in the past? Yes No

Were you under the influence of alcohol at the time these charges occurred? Yes No

If yes, how much did you have to drink? _____

List all of the drugs that you have used in your lifetime even if it was only once

1.) _____ Age at first use _____ Date of last use _____

Age at heaviest usage _____ How often were you using? _____

Pattern of use in the past year (daily, 3x a week, etc.) _____

Methods of use _____

2.) _____ Age at first use _____ Date of last use _____

Age at heaviest usage _____ How often were you using? _____

Pattern of use in the past year (daily, 3x a week, etc.) _____

Methods of use _____

3.) _____ Age at first use _____ Date of last use _____

Age at heaviest usage _____ How often were you using? _____

Pattern of use in the past year (daily, 3x a week, etc.) _____

Methods of use _____

4.) _____ Age at first use _____ Date of last use _____

Age at heaviest usage _____ How often were you using? _____

Pattern of use in the past year (daily, 3x a week, etc.) _____

Methods of use _____

5.) _____ Age at first use _____ Date of last use _____

Age at heaviest usage _____ How often were you using? _____

Pattern of use in the past year (daily, 3x a week, etc.) _____

Methods of use _____

Were you under the influence of any drugs at the time these charges occurred? Yes No

If yes, please specify _____

Do you have easy access to drugs and/or alcohol? Yes No

What triggers you to want to use drugs or alcohol? _____

How are you dealing with staying away from drugs and/or alcohol? _____

Who or what influences you to stay clean/sober? _____

Have you had a substance abuse evaluation since this arrest? Yes No

If yes, by whom? _____

What was their recommendation? _____

TREATMENT HISTORY

Agency _____ When? _____

Inpatient Outpatient Aftercare Education

Did you complete the treatment? Yes No

Agency _____ When? _____

Inpatient Outpatient Aftercare Education

Did you complete the treatment? Yes No

Agency _____ When? _____

Inpatient Outpatient Aftercare Education

Did you complete the treatment? Yes No

EMOTIONAL PERSONAL HEALTH INFORMATION

Are you currently experiencing any symptoms of depression, anxiety, or insomnia? Yes No

Current Diagnosis _____ Agency/Doctor _____

Current Medications/Therapy _____

Date your current treatment started _____

Where have you received mental health treatment in the past?

Diagnosis _____ Agencies _____

Medications/Therapy _____

Have you suffered a traumatic experience that continues to affect your day to day life (such as abuse, natural disaster, war, death of a loved one, witness of a violent act, discrimination)? Yes No

If yes, please explain _____

Have you ever had suicidal thoughts or attempted suicide? Yes No

If yes, please explain _____

Do you act out in a physical manner when you get angry? Yes No

Do you actively seek revenge on others? Yes No

List any physical health problems

Medical Problem

Medication

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies _____

ORIENTATION

How often do you think about potential consequences before making decisions/acting?

What might help you make better decisions in your life?

What are the most significant reasons for the trouble you've had with the law?

What is your overall opinion of the law, police, courts, and corrections systems?

Do you feel your charge(s) is fair? Explain

What changes have you made since this offense to have a better life?

What obstacles will you need to overcome to be successful on probation?

DEFENDANT'S VERSION OF THE OFFENSE

In the space below, write out your side of the story of how this crime happened.
Please sign and date this page when completed

Signature

Date

Iowa Mental Health Screen®

Tony Tatman, Ph.D.
Iowa Department of Corrections, Fifth District

Name: _____ Date of Birth: _____ Today's Date: _____

1. Please list any psychiatric medications you have taken within the last year and what they treat. _____

2. Have you ever been in the hospital for emotional or mental health reasons? YES NO
If "YES", how many times? _____ When was the last time? _____

3. Have you ever been diagnosed with a mental health diagnosis? YES NO
If "YES", what? _____

Please circle your answer to each question, or item that best matches how you currently feel, below. Thank you.

4. 0 I do not feel sad	1 I feel sad	2 I am sad all the time and I can't snap out of it	3 I am so sad and unhappy that I can't stand it	11. 0 I really don't seem to worry about too much	1 I sometimes worry about things, but it really isn't a problem	2 I am worried about things and it's hard to think of much else	3 I worry about things all the time
5. 0 I am not really discouraged about the future	1 I feel discouraged about the future	2 I feel I have nothing to look forward to	3 I feel the future is hopeless and that things cannot improve	12. 0 I feel fine in public places	1 I sometimes feel nervous in public places, but it isn't really a problem	2 My nervousness or fear sometimes keeps me from going out in public	3 My nervousness or fear usually keeps me from going out in public
6. 0 I get as much satisfaction out of things as I used to	1 I don't enjoy things the way I used to	2 I don't get real satisfaction out of anything anymore	3 I am dissatisfied with everything	13. 0 I have not experienced a traumatic event (e.g., witnessed a death, natural disaster, or abuse).	1 I have experienced a traumatic event in my life, but it hasn't really affected me lately	2 I routinely think about, and am impacted by, a traumatic event in my life	3 Effects of a traumatic event in my life impact me in some way every day or most of the time.
7. 0 I don't feel disappointed in myself	1 I am disappointed in myself	2 I am disgusted with myself	3 I hate myself	14. Have you experienced, or have friends or family told you... (circle all that apply)	1 ... you are sleeping less (e.g., sleeping 3 hours a night and feeling rested)	1 ... you are more talkative than usual or an urge to keep talking at times	1 ... have racing thoughts
8. 0 I don't have any thoughts of killing myself	1 I have thoughts of killing myself, but I would not act on them	2 I would like to kill myself	3 I would kill myself if I had a chance	1 ... over activity in fun activities that have a potential for negative consequences (shopping, drinking, sex, travel,...)			
9. 0 I have not lost interest in other people	1 I am less interested in other people than I used to be	2 I have lost most of my interest in other people	3 I have lost all my interest in other people				
10. 0 I can concentrate about as well as I ever could	1 Some days I have problems concentrating, but it really isn't a problem	2 I have greater difficulty concentrating now than I used to	3 I can't really concentrate at all anymore				

Office Use Only

ICON Number: _____

4-14 Total _____

Please circle your answer to each question below.

15. Do you think that people are spying on you?	YES ₁	NO ₀
16. Can you read other people's minds, or hear what other people are thinking?	YES ₁	NO ₀
17. Do you hear things other people couldn't hear, like voices?	YES ₁	NO ₀
18. Do you see things other people couldn't see?	YES ₁	NO ₀

Office Use Only

15-18 Total _____

Please answer these items based on your drinking or drug use in the past year.

19. Have you ever been arrested for an alcohol or drug related charge (e.g., OWI, possession, public intox)?	YES ₅	NO ₀
If "YES", how many times? _____		

		0	1	2	3	4
20.	How often do you have a drink of alcohol or use drugs?	Never	Monthly	2-4 times a month	2-3 times a week	4 or more times a week
21.	How many drinks do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
22.	How often do you have six or more drinks on 1 occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
23.	How often during the last year have you found that you were unable to stop drink or using drugs once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
24.	How often during the last year have you failed to do what was normally expected of you because of your drinking or drug use?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
25.	How often during the last year have you needed a drink or use drugs first thing in the morning?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
26.	How often during the last year have you felt guilt or remorse after drinking or using drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
27.	How often during the last year have you been unable to remember what happened the night before because of drinking or drug use?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
28.	Have you or someone else been injured as a result of your drinking or drug use?	No		Yes, but not in the last year		Yes, during the last year
29.	Has a friend, relative, or doctor or other health worker been concerned about your drinking or drug use or suggest you cut down?	No		Yes, but not in the last year		Yes, during the last year

Office Use Only

19-29 Total _____

Please read each statement carefully and decide if that statement describes you or not. If it describes you, check the word "True"; if not, check the word "False."

30. I always admit my mistakes openly and face the potential negative consequences.	True ₁	False ₀
31. In traffic I am always polite and considerate of others.	True ₁	False ₀
32. I always accept others' opinions, even when they don't agree with my own.	True ₁	False ₀
33. In conversations I always listen attentively and let others finish their sentences.	True ₁	False ₀
34. I never hesitate to help someone in case of emergency.	True ₁	False ₀
35. When I have made a promise, I keep it – no ifs, ands or buts.	True ₁	False ₀
36. I would never live off other people.	True ₁	False ₀
37. I always stay friendly and courteous with other people, even when I am stressed out.	True ₁	False ₀
38. During arguments I always stay objective and matter-of-fact.	True ₁	False ₀
39. I always eat a healthy diet.	True ₀	False ₁
40. Sometimes I only help because I expect something in return.	True ₀	False ₁
41. I sometimes litter.	True ₀	False ₁
42. I take out my bad moods on others now and then.	True ₀	False ₁
43. There has been an occasion when I took advantage of someone else.	True ₀	False ₁
44. I occasionally speak badly of others behind their back.	True ₀	False ₁
45. There has been at least one occasion when I failed to return an item that I borrowed.	True ₀	False ₁

Office Use Only

30-45 Total _____



Iowa Department of Corrections

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BETH SKINNER, PHD, DIRECTOR
DARIN COX, 5TH DISTRICT DIRECTOR

REQUEST/AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient's Name _____

Birth Date: _____

Social Security Number: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, do authorize and request _____
to release information from my (the patient's) medical records to:

**Fifth District
Department of Corrections
1000 Washington Avenue
Des Moines, IA 50314**

Requestor:

Phone:

Fax:

I agree that your agency may release information from _____ to _____ concerning the following medical records:
date date

I hereby authorize the release and/or disclosure of my individually identifiable health information as described below:

Discharge Summary History & Physical Medications Social History
 Evaluation Diagnosis Progress Summary Other

This information is being disclosed and may be used only for the following purpose(s): **Presentence Investigation**

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: (check appropriate box(s))

Mental Health treatment Drug or Alcohol Abuse treatment HIV/AIDS test results

***X**

***In order for this information to be released, you must sign here and below and check the appropriate box(es).**

This authorization is effective for one year from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the treatment facility. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by your treatment facility.

I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand this authorization is voluntary.

Prohibition of Redisclosure

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS test results, federal requirements (42C.F.R. Part 2) and state requirements (Iowa Code ch. 228 & ch. 141) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result for unauthorized disclosure of alcohol/drug abuse or mental health related information or HIV/AIDS test results

Signature of Patient or Patient's Authorized Representative

Relationship of Authorized Representative

Witness (optional)

Date



Iowa Department of Corrections

KIM REYNOLDS, GOVERNOR
CHRIS COURNOYER, LT. GOVERNOR

BETH SKINNER, PHD, DIRECTOR
DARIN COX, 5TH DISTRICT DIRECTOR

AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

NAME: _____ D.O.B.: _____ SSN: _____

A.K.A./MAIDEN NAME: _____

RACE: _____ SEX: _____ EYES: _____ HGT: _____ WGT: _____

I, the undersigned, hereby authorize the Fifth District Department of Corrections to release or obtain information regarding myself, either verbally or in writing **to/from**:

Information disclosed may include my complete case history as listed in my records and any other information relating to my adjustment, treatment, and/or condition. This authorization and consent is not limited to the above, and therefore, it may also include:

I understand that the information to be released is to be used for my **PRESENTENCE INVESTIGATION**. A photo static copy of this authorization and consent form is considered by me to be as valid as the original.

I further understand that my authorization and consent for release of confidential information can be withdrawn by me at any time by written notice to the **Fifth District, Department of Corrections, 1000 Washington Avenue, Des Moines, Iowa, 50314**. I understand that withdrawing this consent will not apply to disclosures made prior to the receipt of a written notice. This authorization and consent will automatically expire **60 days** after the date it is signed, or to comply with drug and alcohol related programs, it will expire **30 days** after the date it is signed or the date of discharge from treatment.

I acknowledge that the information to be released may include material that is protected by state and/or federal law applicable to either mental health or drug/alcohol abuse or both. My signature authorizes release of all such information as specified above.

I understand that upon proper notification to and under appropriate conditions established by the information source listed above, I have the right to inspect the information to be disclosed.

I acknowledge that upon request I may receive a copy of this completed authorization.

SIGNED _____ **WITNESS (optional)** _____ **DATE** _____

INFORMATION REQUESTED

Psychological: diagnosis, treatment records, prognosis/recommendation, discharge summary

Arrests/Dispositions: include conditions of supervision, placements, treatment records

Child Support Records

Medical History

Chemical Dependency: evaluation, treatment records, prognosis/recommendation, discharge summary

School Records, Transcripts, or GED Records (credit & non-credit)

Employment History

Other (Specify) _____

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limit of this consent. Where information has been disclosed from records protected by Federal Law for alcohol/drug abuse records or by State Law for mental health records, Federal Requirements (42 C.F.R. Part 2) and State Requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Sincerely,

Presentence Investigator

Phone:

Fax: (515) 444-2716