Attorney At Law
www.dianeletarte.com
dletarte@earthlink.net

1080 Park Blvd, Suite 1008
San Diego, CA 92101
(619) 233-3688
Fax: (619) 233-3689

Diane T. Letarte, MBA, LLM
MS Forensic Psychology

PERSONAL INFORMATION

Name:	DOB:
Prison Inmate CDC#:	Mailing Address:

WHAT IS THE OFFENSE YOU ARE CURRENTLY SERVING TIME FOR? _____

1) _____ **Are you currently serving a 'three strikes' sentence of 25 years to life?**
   a. Yes
   b. No

2) _____ **Do you authorize the** Law office D. LetaRTE **to represent you on your three strikes resentencing case?**
   a. Yes
   b. No

3) _____ **How did you receive your conviction?**
   a. I plead guilty/no contest knowing I would receive the 3K sentence
   b. I plead guilty/no contest and ran a motion to have the Judge 'strike' my prior strikes
   c. I was found guilty at the end of a jury trial
   d. I was found guilty at the end of a court trial

4) _____ **Were you represented by counsel?**
   a. No, I represented myself
   b. Yes, I was represented by a public defender. Name_____
   c. Yes, I was represented by a private attorney. Name_____
   d. I don't remember

Superior Court Case #:	Appellate Case #:
Date of Conviction:	Date of Sentence:
Presumptive Parole Date:	Prison Counselor Name & Number:

PRIOR CONVICTIONS - Please fill out to the best of your ability

Date	Charge/Offense	Sentence	Strike?

PERSONAL INFORMATION

Has a Romero ever been filed on your behalf? Yes No Do you currently have a copy that you can provide to us? Yes No ** *Do not send unless you receive a request letter* **	If so, please list county & case numbers where filed: _____ _____ _____ _____

What is your first language?	What is the highest grade you completed in school?
Where did you grow up?	Where did you live before going into custody?
Do you currently have family that you keep in touch with? Yes No	If yes, then please provide us with your closest contact: Name: _____ Address: _____ _____ Phone #:
Are you married? Yes No	If yes, then please provide us with your spouse/partners contact information: Name: _____ Address: _____ _____ Phone #:
Do you have any children? Yes No Do you keep in touch with your children? Yes No	Please list your children's name, age & where they live:

PRIOR ATTORNEY INFORMATION - *Fill in to the best of your ability. If you only remember some parts that's okay.*

Trial Attorney on case serving current sentence on:

Name	
Address	
Telephone	

Your Appellate Attorney (for your direct appeal)

Name	
Address	
Telephone	

Your State Habeas and/or Federal Habeas Attorney(s) (*if you had one filed*)

Name	
Address	
Telephone	

Prosecution's Trial Attorney / District Attorney

Name	
Address	
Telephone	

TRIAL JUDGE who committed you to state prison for 25 to life: _____

REHABILITATION

How many years have you been in custody? _____

Please describe below any programming you have done in the following categories:

Drug Addiction	
Alcohol Addiction	
Anger management	
Sex Offender Trtmnt	
Religion	
Education i.e., GED, certifications	
Tattoo Removal	
Gang Intervention	
Physical Fitness	
Life Skills	

Since being in custody have you dealt with any of the following – please describe the diagnosis & how you have treated

Medical Issues	
Mental Health Issues	
Of those listed above were you ever diagnosed prior to going into custody? If yes, please list:	

DOCUMENTATION *Check those documents that you can make available to us. Please **DO NOT SEND ANYTHING UNTIL YOU ARE REQUESTED TO DO SO BY AN ATTORNEY FROM OUR OFFICE.***

FUTURE PROSPECTS

If you were to be released where would you live?	
Do you have family there?	
If you were released what kind of work would you do?	
What job training do you have that would serve you in the outside world upon release?	
Will you abide by the conditions of a parole release?	
Will you continue to pursue any type of treatment or rehabilitation? If so, please list.	
If you are released what will you do in your spare time?	

INSTITUTION BEHAVIOR (CDC-115, CDC-128,etc)

PROGRAMMIMG (AVP classes, Conflict Resolution, etc)

CONSENT FOR RELEASE OF INFORMATION

By signing below, I authorize the Law Office of Diane T. Letarte to assign one or more attorneys, paralegals, investigators, and/or law student interns, (who may be working under the direct and immediate supervision of an attorney), to investigate my case for the possibility of filing a resentencing relief claim under the newly passed Proposition 36, also known as the Three Strikes Reform Act.

This includes, but is not limited to, authorizing correspondence and/or telephone calls to prior counsel, prosecutors, or witnesses. I authorize any and all entities and persons, including my former attorney(s), investigator(s), Innocence Project(s) and appellate programs who worked on my case, to release to the Law Office of D.T. Letarte or to its attorney's, legal support staff or student intern representatives, any and all records, files, reports, and information of any kind related to me or to any criminal case involving me, including police reports, witness statements, post-conviction pleadings, and correctional records, presentencing reports and other documents in prison social services and legal files, legal papers, court documents, medical records, laboratory analyses, probation reports, attorneys files and records, and any other information necessary to the Law Office of D. Letarte Office's work on my behalf.

I understand there may be statutes, rules, and regulations that protect the confidentiality of some of the records, files, reports, and information covered by this release; it is my specific intent to waive the protection of all such statutes, rules, and regulations so that confidential information can be shared with the Law Office of Diane T. Letarte.

By my signature below, I represent that this waiver is voluntary and given without any reservation. This authorization is effective until revoked by the undersigned in writing.

By my signature below, I am authorizing the Law Office of Diane T. Letarte to represent me in any phase of litigation with respect to resentencing under the Three Strikes Reform Act.

_____

Date

_____

Signature

_____

Printed Name

_____

Prison Inmate Number

_____

Date of Birth

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AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR INFORMATION

Last Name:	First Name:	Middle Name:	Date of Birth:

Address:	City/State/Zip:	CDC/YA Number:

Person/Organization Providing the Information	Person/Organization to Receive the Information
Name: _____ Address: _____ City/State/Zip: _____ Phone #: (____) _____ Fax Number: (____) _____	Name: _____ Address: _____ City/State/Zip: _____ Phone #: (____) _____ Fax Number: (____) _____

[45 C.F.R. § 164.508(c)(1) (iii) & Civ. Code § 56.11(e), (f)]

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code §§ 56.11(d) & (g)]

☐ Medical	☐ Mental Health	☐ Genetic Testing
☐ Dental	☐ Substance Abuse/Alcohol	☐ Communicable Disease
☐ HIV	☐ Psychotherapy Notes	☐ Other (Please Specify)

_____

For the following period of time: From _____ (date) to _____ (date)

Description of Each Purpose for the Use or Release of the Information
(Indicate how the information will be used)
[45 C.F.R. § 164.508(c)(1)(iv)]

☐ Health Care	☐ Personal Use	☐ Legal

☐ Other (please specify) _____

Will the healthcare provider receive money for the release of this information?
[45 C.F.R. § 164.524(c)(4)(i), (ii)]

Reasonable fees may be charged to cover the cost of copying and postage.

This authorization for release of the above information to the above-named persons/organizations will expire on: _____ (date). [45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

I understand:

- **I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i)]**
- **I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health Records department at my current institution. The authorization will stop further release of my health information on the date my valid revocation request is received in the Health Records department. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.11(h)]**
- **I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]**
- **Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have 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. [45 C.F.R. 164.508(c)(2)(ii)]**
- **I understand I have the right to receive a copy of this authorization. [Civ. Code § 164.508 (c)(4) and Civ. Code § 56.11(i)]**

Signature:	CDC/YA Number:	Date:

[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Representative:	Relationship:	Date:

[45 C.F.R. § 164.508(g)(1) & Civ. Code § 56.11(c)(2)]

This authorization form complies with 45 CFR parts.160 & 164, Welfare and Institutions Code Section 5328, 42 CRF part 2

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA

(Medical, Mental Health, and Drug and Alcohol Treatment Records)

This authorization pertains to records for the following individual:
Name: Last _____ First _____ Middle: _____
Date of Birth: _____

I, _____, authorize and request all entities and persons listed on this form to disclose the confidential information specified in this form to the

SIGNATURE: _____
Client Date

PURPOSE: The Law office of Diane T. Letarte may use the information disclosed solely for the purpose of the legal representation of _____, case no. _____.

DURATION: This authorization is valid on the date it is executed and will remain valid for three years from that date unless it is earlier revoked by me or until an earlier date designated in the following space _____(date).

REVOCATION: I understand that I have a right to revoke this authorization at any time except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. A revocation (1) must be in writing, (2) sent or given to the Law Office of Diane T. Letarte, or to the treatment provider directly, and 3) is effective when it is received by the Law Office or treatment provider. Once revoked, no further disclosures may be made of your protected health information.

CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for health benefits will not be based on my giving or refusing to give this authorization, except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.

I understand that I have the right to receive a copy of this authorization form if I request a copy. I also understand that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and may no longer be protected by Federal and State confidentiality laws.

MEDICAL RECORDS

I authorize _____ *(treatment provider)* to disclose the following records:
Records Requested (description and dates of treatment):

Signature: _____ Date: _____

This authorization form complies with 45 CFR parts 160 & 164, Welfare and Institutions Code Section 5328, 42 CRF part 2.

DRUG AND ALCOHOL TREATMENT RECORDS

I understand that drug and alcohol treatment records are confidential and treatment providers are prohibited by both 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) from disclosing these records without a client's specific authorization or as otherwise required by law as set forth in the treatment provider's Notice of Privacy Practices. By signing this authorization form, I authorize the release of information contained on this form to all entities and persons listed on this form. With this understanding, I authorize _____ *(insert name of provider)* to release the following records:
Records Requested (description and dates of treatment):

_____

Signature: _____ Date: _____

MENTAL HEALTH TREATMENT RECORDS

I understand that mental health treatment records are confidential, as set forth in California Welfare & Institutions Code, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be disclosed without specific authorization, or as otherwise required by law as set forth in the treatment provider's Notice of Privacy Practices. With this understanding, I authorize _____ *(insert name of treatment provider)* to release the following records:
Records requested (description and dates of treatment):

_____

Signature: _____ Date: _____
Printed Name: _____

Mental Health Provider: *I certify that I am the current treating provider and I have reviewed the request and authorization for mental health records and declare the following:*

_____ *In my professional judgment, I approve the release of the requested mental health records consistent with this authorization.*

_____ *I do not authorize the release of the requested mental health records because: I have determined that access to the records requested by the patient would have either a detrimental effect on the provider's professional relationship with the minor, or the minor's physical safety or psychological well being.*

_____ *I do not authorize the release of the requested mental health records because I have made a clinical determination that there is a substantial risk of significant adverse or detrimental consequences to the patient in reviewing her/his mental health records.*

Provider Signature: _____ Date: _____
Title: _____

For Staff Use:
Copies to & date given: