**AUTHORIZATION FOR RELEASE OF INFORMATION**

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_, authorize you to allow any attorney, legal intern, paralegal, or other representative of the Legal Aid Justice Center to review, discuss, collect and/or make a copy of my records, documents, or personal property for the purpose of legal representation.

I request that you make available the records checked below:

□ Complete Medical Records □ X-Ray Results □ School Records

□ Outpatient Medical Care □ Laboratory Results □ Employment Records

□ Inpatient Medical Care □ Financial Information

□ Governmental Records including, but not limited to, Social Security, Social Services, Dep’t of Juvenile Justice, and Court records

Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If my/my child’s records contain the following information, it is released if **INITIALED.**

\_\_\_\_\_\_Substance Abuse \_\_\_\_\_\_Mental Health Care/Assessment(s)

\_\_\_\_\_\_HIV Testing or Care \_\_\_\_\_\_Sex Offender Treatment

I understand that my health and mental health records are protected by federal and/or Virginia law from disclosure without my consent. I understand that my health care treatment will not be conditioned upon my signature. I also understand that the Legal Aid Justice Center may give this information to someone else, and therefore it may no longer be protected under the HIPAA privacy law. My consent is voluntary.

A photocopy of this release shall be considered as valid as an original.

I can revoke this authorization at any time through a written notice to the Legal Aid Justice Center. This authorization is in effect as long as the Legal Aid Justice Center is representing me, or until I revoke this release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Releasing Records Date

□ I am the Parent, Guardian, or Legally Authorized Representative of the person who is the subject of the request. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_