AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____ Client's DOB: _____

Client's SSN: _____ Client's Medical Record #: _____

I hereby designate the Law Office of _____ as my agent to request and receive on my behalf documents or information relating in any manner to me for the purpose of legal representation, **including but not limited to records protected pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

I release custodians and possessors of such information from any and all liability for its disclosure to my agent. This authority includes, but is not limited to, the inspection, copying, and receipt of documents, photographs, written or recorded information and the receipt of oral information. I hereby request that all persons cooperate fully in providing the requested information.

The authority herein granted applies, but is not limited to: all medical reports of physical and/or mental disorders, specifically including reports relating to the following (*client to check and initial if the following specific information is to be released*):

☐ _____ (initials) Alcohol and/or Drug treatment records

☐ _____ (initials) HIV/AIDS records

☐ _____ (initials) Mental Health/Psychiatric treatment records

The authority herein granted includes, but is not limited to medical records for the following period of time:

From: _____ To: _____ ☐ All Records

The authority here granted includes, but is not limited to, information requested from the following: Patton State Hospital, Atascadero State Hospital, Coalinga State Hospital, California Department of Corrections and Rehabilitation, Children's Hospital, San Diego Department of Health and Human Services Agency, County of San Diego Department of Mental Health Services, Selective Service, Military, Veterans Administration, San Diego Regional Center for the Developmentally Disabled, law enforcement and penal correction facilities, California Department of Public Social Services, the United States Department of Immigration and Naturalization, Internal Revenue Service Social Security Administration, Patton State Hospital all medical facilities and treatment programs, doctors, psychiatrists, attorneys, financial institutions and all schools, or _____

I further state that this consent is valid, absent my express revocation thereof, for twenty-four (24) months, from the date of my signature. A photocopy or facsimile will serve as an original.

I may revoke this authorization at any time prior to its expiration by notifying the Office of the Public Defender in writing, but the *revocation will not be effective to the extent that we or others have acted in reliance upon this authorization.*

I am not required to sign this form to receive health care services (or for enrollment in a health plan, treatment, payment or eligibility for benefits).
I will receive a copy of this form if I request it. (A copy must be issued to client for mental health record releases).

The information that is used or disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal privacy regulations. However, any information disclosed to health care providers, insurance companies, and health plans will continue to be protected and not to be reused or re-disclosed other than as authorized by you or permitted by law.

I have read this authorization for release of information with my attorney and fully understand its contents and my rights pursuant to HIPAA .

Client's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised: April 10, 2009