CONSENT TO RELEASE MEDICAL, DENTAL, AND PSYCHIATRIC INFORMATION TO FAMILY MEMBERS

This form or photocopy thereof shall authorize the Prison Law Office attorneys, employees, and/or representatives to release to NAME(S)/RELATION(S) ______________________________

any and all of my medical, dental and psychiatric records and information from DATE____________________ to the present in their possession, and further authorizes the examination and copying of said records and information. This authorization to release, examine, and copy records or information includes, pursuant to California Health and Safety Code section 120980, the results of an HIV test and any records or information pertaining to my care and treatment resulting from or subsequent to any such tests.

This authorization shall be in effect and valid for one year from the date of signature, unless it is earlier revoked. I have been advised that I have the right to revoke this authorization in writing at any time, and may do so by sending a written statement with my name, signature, date, and CDC number to: Prison Law Office, General Delivery, San Quentin, CA 94964, stating that I am revoking my authorization to disclose the protected health information identified in this authorization form.

I further understand that the information disclosed pursuant to this authorization may be redisclosed by the above named attorneys or their employees or representatives and therefore no longer protected by the federal privacy rule regulations under the Health Insurance Portability and Accountability Act ("HIPAA").

I have been advised that I have a right to receive a copy of this authorization upon demand.

Date: ____

Signature

____

Print Name

____

CDC Number