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 any and all information contained in my medical, dental and psychiatric records and information to:

(*please write name(s), relationship(s), contact information of person(s) on lines below*)

_____

_____

_____

from (*starting date*) _____ to present.

This authorization shall be in effect and valid for two years 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 ADC 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 form.

I further understand that the information disclosed pursuant to this authorization may be redisclosed by the above named attorneys and 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

_____

ADC Number