CONSENT TO RELEASE MEDICAL, DENTAL, AND PSYCHIATRIC INFORMATION TO ATTORNEY AND OTHERS

This form or photocopy thereof shall authorize the Board of Prison Terms, California Youth Authority, California Department of Corrections and Rehabilitation, all private and public health care, mental health and dental care providers, and their employees or agents to release any attorneys, employees, and/or representatives of Sixth District Appellate Program, Inc., any and all of my medical, dental and psychiatric records and information from _____ 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.

Such information may be disclosed by the above named attorneys or their employees or representatives for the purpose of advocating on my behalf with respect to any appeal, habeas petition, claim, complaint, or grievance I might have concerning my crimes of conviction and/or the sentence imposed, or pertaining to any medical condition or conditions of confinement.

This authorization shall be in effect and valid for five 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 CDC number to: Sixth District Appellate Program, Inc., 100 N. Winchester Blvd., Suite 310, Santa Clara, CA 95050, stating that I am revoking my authorization to disclose the protected health information identified in this authorization form.

I understand that the Board of Prison Terms, California Youth Authority, California Department of Corrections and Rehabilitation and their employees or agents may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign 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