



AUTHORIZATION AND RELEASE

I authorize _____ to release medical information

related to this incident to: _____
Facility Name

- | | |
|---|--|
| <input type="checkbox"/> State Office of Victim Assistance (SOVA) | <input type="checkbox"/> Department of Social Services |
| <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Community Based Prevention Services |
| <input type="checkbox"/> Guardian ad Litem | <input type="checkbox"/> Solicitor |

and hold harmless this facility and its staff, from any and all liability and claims of injury which may in any manner result from the release of such information.

I also authorize the release of medical information to/from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Private Physician | <input type="checkbox"/> Mental Healthcare Provider | <input type="checkbox"/> Children's Advocacy Center |
| <input type="checkbox"/> Other <i>Specify</i> _____ | | |

for the continuing diagnosis and treatment of this child.

I request and authorize the State Office of Victim's Assistance (SOVA) to assign the payment for medical services provided on this child's behalf to:

Facility Name _____

Address _____

City _____ State _____ Zip Code _____

I permit a copy of this authorization to be used. I understand that I have the right to withdraw this authorization at any time by notifying this facility in writing. I understand that the withdrawal is not effective for any actions taken prior to this withdrawal. Without a written notice to withdraw this authorization, it will expire 1 year from the date the medical service is provided.

Child's Name: _____ Date of Birth: _____ SSN: _____
(Last 5 digits)

Address: _____

Contact Phone Number _____

By signing, I consent to the authorization and release of medical information of the named child as described above.

Signature of Parent/Legal Representative Printed Name Date: _____

Signature of Parent/Legal Representative Printed Name Date: _____

Signature of Witness Printed Name Date: _____