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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client/Student/Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to provide the confidential information and records to _Sydnor Law Firm, PLLC_ or it's staff. This authorization applies to inspecting and copying:

_X_ Health Care Information & Records
_X_ Financial Information & Records
_X_ Legal Information & Records
_X_ Juvenile Court Record
_X_ School Records & Information
_X_ Educational Tests & Results
_X_ Discharge Summaries & Other
_X_ Juvenile Court Counselor Record

I also consent to the release of all health care information and records relating to the testing, diagnosis and treatment of:

X Mental illness and/or psychiatric disorders
X Alcohol and/or drug abuse
X Sexually transmitted diseases, including HIV/AIDS

Need for Disclosure: ___Investigation and possible representation_____

This authorization expires in one (1) year, but may be revoked at any time, except to the extent the holder of the information/records has already taken substantial action in reliance on the authorization. Any further disclosure may be made only as provided by law. A photocopy of this form is as valid as the original. Treatment, payment, enrollment, and/or benefit eligibility is not contingent upon signing this form. I understand that the information to be released is protected under Federal Confidentiality Regulation and other federal law. I also understand that the disclosed information may be subject to redisclosure and therefore no longer protected under federal law. My signature below authorizes release of all such records and information.

_____ _____
Client/student/patient or Authorized representative (Signature) Date

_____
Relationship of representative to client/student/patient

_____
Printed Name of Representative