

LAW OFFICE OF THE
PUBLIC DEFENDER

**JUVENILE DIVISION
DEKALB COUNTY**

STONE MOUNTAIN JUDICIAL CIRCUIT

RE: School Records

AUTHORIZATION TO DISCLOSE HEALTH AND/OR EDUCATIONAL INFORMATION

Youth's Name: _____ Date of Birth: ____/____/____

I, _____, authorize the Law Office of the Public Defender, Juvenile Division to obtain from ~~release to~~ _____ the following information:

- | | |
|---|--|
| <input type="checkbox"/> The Entire Medical Record | <input type="checkbox"/> Initial Clinical Assessment |
| <input checked="" type="checkbox"/> Psychiatric Evaluation | <input checked="" type="checkbox"/> Psychological Evaluation |
| <input checked="" type="checkbox"/> Psychosocial History | <input type="checkbox"/> Medication Record |
| <input type="checkbox"/> Dates of Hospitalization | <input checked="" type="checkbox"/> Treatment Notes, Plans & Recommendations |
| <input type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> Psychoeducational Evaluation |
| <input checked="" type="checkbox"/> Special Education Records | <input checked="" type="checkbox"/> IEP/504/SST Records (last 2 years) |
| <input checked="" type="checkbox"/> Behavioral/Disciplinary Reports | <input checked="" type="checkbox"/> Standardized Test Scores (last 2 years) |
| <input checked="" type="checkbox"/> Other: <u>see attached subpoena duces tecum</u> | |

The purpose of this disclosure is for legal representation and advocacy. I understand that this authorization allows representatives from the Law Office of the Public Defender to speak to and/or meet with school officials, hospital staff and community agencies on my behalf with or without my presence. They may also meet with the youth at school as needed.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to my attorney. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, this event or condition: N/A. If I fail to specify an expiration date, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure representation. I understand that the information obtained will be used to assist in my defense or to facilitate treatment/aftercare services. I understand any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Parent, Guardian or Legal Representative

Date

If signed by Legal Representative, Relationship to Youth

Witness

CLAUDIA S. SAARI CIRCUIT PUBLIC DEFENDER

LAW OFFICE OF THE
PUBLIC DEFENDER

**JUVENILE DIVISION
DEKALB COUNTY**

STONE MOUNTAIN JUDICIAL CIRCUIT

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Youth's Name: _____ Date of Birth: ____/____/____

I, _____, authorize the Law Office of the Public Defender, Juvenile Division to obtain from/release to _____ the following information:

<input type="checkbox"/> The Entire Medical Record	<input type="checkbox"/> Initial Clinical Assessment
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Psychological Evaluation
<input type="checkbox"/> Psychosocial History	<input type="checkbox"/> Medication Record
<input type="checkbox"/> Dates of Hospitalization	<input type="checkbox"/> Treatment Notes, Plans & Recommendations
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychoeducational Evaluation
<input type="checkbox"/> Special Education Records	<input type="checkbox"/> IEP/504/SST Records (last 2 years)
<input type="checkbox"/> Behavioral/Disciplinary Reports	<input type="checkbox"/> Standardized Test Scores (last 2 years)
<input type="checkbox"/> Other: _____	

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Signature of Youth or Legal Representative

Date

If signed by Legal Representative, Relationship to Youth

Witness

CLAUDIA S. SAARI CIRCUIT PUBLIC DEFENDER