AUTHORIZATION AND RELEASE

I authorize _____ to release medical information related to this incident to:
Facility Name

☐ Department of Crime Victim Compensation (DCVC)
☐ Department of Social Services
☐ Law Enforcement
☐ Guardian Ad Litem
☐ 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:

☐ Private Physician ☐ Mental Healthcare Provider ☐ Children's Advocacy Center
☐ Other *Specify* _____

for the continuing diagnosis and treatment of this child.

I request and authorize the Department of Crime Victim Compensation (DCVC) 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 the date of 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 on 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