

AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION

TO: DEPARTMENT OF JUVENILE JUSTICE

I authorize you to allow any attorney, legal intern, paralegal, or other representative of _____ to review, discuss, and make a copy of my records (or my child’s records if the subject of the records is a minor).

Subject’s Name: _____ Date of Birth: _____

I request that you make available the records checked below:

- Court Records
- Classification Records
- Institutional Disciplinary Records
- Entire DJJ File

I request that you make available the records **INITIALED** below:

- Medical Records
- Mental Health Records
(excluding psychotherapy notes)
- Psychotherapy notes
- Sex Offender Treatment Records
- Substance Abuse Records
- Education Records

I understand that some of the medical, substance abuse, psychotherapy, and sex offender treatment records are protected by federal law and/or Virginia law from disclosure without my consent. I give my consent by initialing above. My consent is voluntary.

A photocopy of this release shall be considered as valid as the original.

I can revoke this release at any time through a written notice to the _____ (requesting entity). I understand my authorization will not be revoked as to a releasing agency until the releasing agency receives written notification of the revocation. A revocation will not apply to any records already released at the time of revocation. This authorization is in effect for one year from the date signed, or until _____ (requesting entity) no longer represents me, whichever occurs first.

Subject’s or Parent/Guardian’s printed name

Signature

Date