AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION

TO: DEPARTMENT OF JUVENILE JUSTICE

I authorize you to allow ____(the party receiving the records, including contact information) 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

___ Disciplinary Records ___ Entire File

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

___ Medical Records ___ Mental Health Records (excluding psychotherapy notes)

___ Psychotherapy notes ___ Education Records

___ Substance Abuse Records ___ Sex Offender Treatment 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 receiving 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______________, _____, (if less than one year).

____

Subject's or Parent/Guardian's printed name

____ ____________________________

Signature Date