AUTHORIZATION TO RELEASE RECORDS

I authorize the release of records, documents, or other information concerning

_____ to _____ or any other staff employed at LEGAL SERVICES FOR CHILDREN, INC., 1254 Market Street, Third Floor, San Francisco, California 94102, (415) 863-3762.

This release includes the following: (please initial)

_____ Medical, psychological, or psychiatric records (including, but not limited to records of diagnoses and treatment): _____

_____ School records: _____

_____ Financial records: _____

_____ All records in the possession of any county Department of Human Services/ Social Services

_____ All records in the possession of any county Juvenile Probation Department

_____ All records in the possession of the Social Security Administration (SSA)

_____ Other: _____

_____ Other: _____

A copy of this Authorization shall be as valid as the original. This Authorization is effective immediately and expires one year from the date below.

Dated: _____

Signature: _____

_____