Community Veteran Justice Project
► CVJP.ORG
► office.cvjp@gmail.com
Social and Environmental Entrepreneurs (SEE)
23532 Calabasas Road, Suite A
Calabasas, CA 91302

AUTHORIZATION FOR USE: DISCLOSURE OF CLIENT INFORMATION

Client's Name (Last, First, MI): _____

Birth Date (mm/dd/yyyy): _____

Address: _____ City: _____

Zip Code: _____ State: _____ Email: _____

Phone: _____ Phone secondary: _____

Community Veteran Justice Project (CVJP) may release this information to:

☐ DEPARTMENT OF VETERANS AFFAIRS
☐ VETERANS JUSTICE OUTREACH PROGRAM
☐ LA COUNTY BAR ASSOCIATION VETERAN'S PROJECT
☐ VETERANS SERVICE ORGANIZATION(S)
☐ LEVITT AND QUINN LAW FIRM
☐ VETERAN PEER ACCESS NETWORK
☐ SAFE HOUSE COMMUNITY PROGRAM
☐ LOS ANGELES HOMELESS SERVICES AUTHORITY
☐ NEIGHBORHOOD LEGAL SERVICES
☐ LA COURT(S)
☐ LA PUBLIC DEFENDER
☐ CASIO SHYN
☐ MARK ROSENFELD
☐ MATHEW MILLEN
☐ OTHER (specify): _____

The following information may be disclosed:

☐ LEGAL
☐ DISABILITY
☐ VA BENEFIT(S)
☐ EDUCATION
☐ PENSION(S)
☐ DISCHARGE UPGRADE
☐ MEDICAL CONDITION VERIFICATION
☐ MENTAL HEALTH INFORMATION
☐ DRUG/ ALCOHOL RELATED INFORMATION
☐ TICKET(S)/ EXPUNGEMENT
☐ DIVORCE/ CHILD CUSTODY SUPPORT
☐ IMMIGRATION/ CITIZENSHIP
☐ HOUSING
☐ EVICTION(S)
☐ EMPLOYMENT
☐ OTHER (specify): _____

The information released under this authorization will be used for the following purpose(s):

☐ APPLICATION OF BENEFITS
☐ ASSESS FOR INTAKE PURPOSE(S)
☐ COORDINATE CARE
☐ REFER FOR SERVICE(S)
☐ REVIEW HISTORY
☐ OTHER (specify): _____

This information will be used to provide comprehensive and coordinated services. A copy of this authorization will be as valid as the original. You have a right to a copy of this completed authorization. This consent will expire as designated below, but in no case will it expire later than one year from the date of your signature. You consent freely and voluntarily and understand that refusal to grant authorization will not prevent you from utilizing services upon acceptance to CVJP.

REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the CVJP (address on the header of this form). Your cancellation will not affect information that was released prior to receipt of the written request.
REDISCLOSURE: Once this information is released, it is protected under federal privacy law and Insurance Portability and Accountability Act of 1996 (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.
CONFIDENTIALITY: The confidentiality of this record is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records as well as Title 42 of the United States Code.

Records released as part of this authorization may contain references related to mental health, addiction, medical evaluations, and information related to military service. CVJP may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request.

Delivery Preference: ☐ ELECTRONIC ☐ PAPER MAIL ☐ PICKUP

_____ _____ _____
Date (mm/dd/yyyy) Signature If personal representative, print name/relationship

DO NOT FILL OUT AND SIGN BELOW UNLESS YOU WISH THIS AUTHORIZATION TO EXPIRE BEFORE 1 YEAR OF TIME

Expiration date (mm/dd/yyyy): _____
Note: Release expires 1 year after the date signed by the person served unless otherwise noted here.

I, _____ have decided to withdraw my authorization for CVJP to obtain or disclose protected health information to the above person, provider, or agency.

Date (mm/dd/yyyy): _____ Signature of person served (or authorized representative): _____