Community Veteran Justice Project
► CVJP.ORG
► office.cvjp@gmail.com
Social and Environmental Entrepreneurs (SEE)
23564 Calabasas Road, Suite 201
Calabasas, CA 91302

Client's name (First, Last): _____
Birth Date (mm/dd/yyyy): _____
Address: _____ City: _____
Zip Code: _____ State: _____ Email: _____
Phone: _____Phone secondary: _____

RELEASE OF INFORMATION

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

- ☐ Courthouse
- ☐ Attorney
- ☐ Public Counsel Service(s)
- ☐ Safe House Community Program
- ☐ LA Homeless Services Authority
- ☐ Neighborhood Legal Services
- ☐ LA County Bar Association Veterans Project
- ☐ Veterans Service Organization (VSO)
- ☐ Veterans Justice Outreach letter | VJO
- ☐ Veteran Readiness and Employment (Vr&E) | Vocational Rehab)
- ☐ Veteran Peer Access Network | VPAN
- ☐ Entrepreneur Bootcamp
- ☐ USC Small Business Clinic
- ☐ Los Angeles County Bar Association (LACBA) Entrepreneur
- ☐ Small Business Administration (SBA)
- ☐ US VETS
- ☐ Village for vets
- ☐ Veterans Resource Center (VRC)
- ☐ LA veteran collaborative employment group
- ☐ Public Counsel Service(s)
- ☐ LA court(s)/LA public defender
- ☐ Mathew Millen (Citizenship and Immigration assistance)
- ☐ Mark Rosenfeld (DMV Hearing | Ticket(s) | Expungement(s) assistance)
- ☐ Levitt and Quinn law firm (Divorce | Child Custody Support assistance)

OTHER (specify): _____

The following information may be disclosed:

- ☐ Disability
- ☐ VA benefit(s)
- ☐ Pension(s)
- ☐ Mental Health
- ☐ Drug | Alcohol
- ☐ MediCal
- ☐ Department of Military & Veterans Affairs | DMVA
- ☐ Department Of Mental Health (DMH)
- ☐ Housing
- ☐ Veterans Affairs
- ☐ Drug | Alcohol
- ☐ Education
- ☐ Identification document | ID:
- ☐ Financial literacy
- ☐ Transportation
- ☐ Metro bus card
- ☐ Citizenship
- ☐ DMV Hearing | Ticket(s) | Expungement(s)
- ☐ Divorce | Child Custody Support
- ☐ Veterans Justice Outreach letter | VJO

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): _____