AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name:
D.O.B.:

Pursuant to §81.103(d), Texas Health & Safety Code and any other applicable laws, I, the undersigned, authorize the Capital Area AIDS Legal Project ("CAALP"), AIDS Services of Austin ("ASA"), if applicable, and the employees, agents, and/or volunteers working for CAALP and/or ASA (if applicable) to disclose my identity, address, phone number, the fact that I have a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or HIV Disease, and other necessary information regarding my legal matter(s) with the following individuals and/or organizations identified below. This release is restricted to the persons and/or organizations listed below. No information which might identify me, may be shared by CAALP, ASA, and/or employees, agents, and/or volunteers working for CAALP and/or ASA, with any other person or organization.

Releases Authorized:

Any employee, agent, or volunteer working on behalf of CAALP and/or Volunteer Legal Services of Central Texas, 1033 La Posada Dr., Suite 374, Austin, TX 78752, 512-476-5550 _____ _____/_____
Name/Title/Agency/Telephone Client Initials/Date

_____ _____/_____
Name/Title/Agency/Telephone Client Initials/Date

_____ _____/_____
Name/Title/Agency/Telephone Client Initials/Date

I understand that this authorization to disclose/obtain information may be revoked at any time. This consent, unless revoked sooner by me, will expire one year from the date of my signature unless I indicate some other date here: (date) _____.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date