Authorization for Release of Personal Information & Representation
To: Family Advocacy Attorney at The Center for Family Safety and Healing

I, ____________________________________, understand that the Family Advocacy Attorney at The Center for Family Safety and Healing may need to review or copy personal information about me or my children in connection with my case.

I **AUTHORIZE** each and every governmental or private agency, company or person who has or maintains any health, medical, financial, legal, educational or other personal information about me or my children to RELEASE that information to the Family Advocacy Attorney.

I **AUTHORIZE** the Family Advocacy Attorney to act on my behalf and serve as my representative in requested matters.

This authorization automatically ends one year from the date written below, or earlier, if I cancel it in writing.

____________________________________ My Signature	______________________ My date of birth
____________________________________ Child(ren)'s Name(s)	______________________ Children's birthdates
____________________________________ Witness	______________________ Today's Date