ATTORNEY LETTERHEAD HERE

AUTHORIZATION

This document, or a photocopy thereof, will verify that my attorney is authorized to communicate with probation officers, prior attorneys, prison authorities, psychiatrists, psychologists, physicians and all other persons having information which my attorney deems necessary to represent me. I further authorize my attorney to examine, inspect and make photocopies of all probation reports, documents in the possession of my prior attorneys, employment records, prison records, medical records, psychiatric records, and all correspondence, reports, charts and any other documents pertaining to me. To the extent necessary, I waive my health information privacy rights provided by the Health Insurance Portability and Accounting Act (HIPAA).

DATED: _____ _____

(Signature)

_____

(Please print name)