Equal Justice Foundation
455 Bear Creek Road
Colorado Springs, CO 80906-5820
Telephone: (719) 520-1089
Email: comments@ejfi.org
Web site www.ejfi.org
Domestic Violence Against Men in Colorado: www.dvmen.org
Combined Federal Campaign 18855

Permission by Army Spc. Deonte J. Carter and wife Whitney N. Pressley Carter for release of medical, personal, and such other information as necessary with regard to Fourth Judicial District Case Number 2011JV1220 as well as medical information regarding minor child Javen Deon Carter

To Whom It May Concern

Notice is hereby given to all parties that Charles E. Corry, Ph.D., President of the Equal Justice Foundation, has our full and free permission to release any such information provided to him by Deonte Carter and his wife, Whitney Carter, that he, at his sole discretion, deems essential and necessary to provide to any third party with relation to case number 2011 JV 1220 concerning their minor child Javen Deon Carter.

Spc. Carter and wife Whitney fully understand their rights to privacy regarding medical information and have signed separate HIPAA release forms as well.

Deonte Carter — Date: 10/30/2011

Whitney Pressley Carter — Date: 11/02/2011

Charles E. Corry — Date: 11/2/2011

Charles E. Corry, Ph.D.
Equal Justice Foundation
455 Bear Creek Road
Colorado Springs, CO 80906
Telephone: (719) 520-1089
Email: ccorry@ejfi.org

HIPAA Release of Information
AUTHORIZATION FORM

I, SPC Deonte Carter hereby authorize Equal Justice Foundation and its affiliates, its employees and agents (collectively Evans Army Hospital), to release to Charles F. Carry Ph.D **[Insert full name of person/organization]** my personal health information maintained by Javen Deonte Carter (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

N/A **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of ~~10/30/2011~~ 12/31/12 **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with 12/31/2012.

I understand that I have a right to revoke this authorization by providing written notice to Charles F. Carry Ph.D. However, this authorization may not be revoked if Equal Justice Foundation's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

~~Name of Member:~~ Deonte Carter

~~Signature of Member:~~ [signature]

Date: 10/31/2011

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

HIPAA Release of information
AUTHORIZATION FORM

I, Whitney Carter hereby authorize Equal Justice Foundation and its affiliates, its employees and agents (collectively _____), to release to Charles E. Corry PhD. **[Insert full name of person/organization]** my personal health information maintained by _____ (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

N/A **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of 12/31/2017 **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with 12/31/2012

I understand that I have a right to revoke this authorization by providing written notice to Charles F. Corry. However, this authorization may not be revoked if Equal Justice Foundation's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name ~~of Member~~: Whitney P Carter

Signature ~~of Member~~: Whitney P Carter

Date: 11/2/2011

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____