



CITIZENS COMMISSION ON HUMAN RIGHTS®

Established in 1969 by the Church of Scientology® to investigate and expose psychiatric violations of human rights

LOS ANGELES CHAPTER

Authorization for Confidential Information

[HIPAA Compliant]

TO:

RE:

Patient Name:

DOB:

SSN:

My abuse by

Todd Michael Giffen

3/13/1985

542-13-0969

My website:


obamasweapon.com

Phone:

503-967-5202

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with investigation of a legal claim, including police records, insurance records, financial records, medical records and all other records that may be considered confidential. I expressly request that the designated record custodian of all covered entities under HIPAA or any other law protecting confidential records identified above disclose full and complete protected information including the following:

All medical and legal records including psychiatric records and psychological notes, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, records showing any detention pursuant to law and records received from other medical providers.


Initials

7671 McGroarty St, Tujunga California 91042

Phone: 818-669-3075

To report psychiatric abuse or fraud, call 900-942-2247

All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

All employment, personnel or wage records.

All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits forever.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.


This protected health information is disclosed for the following purposes:

Review and evaluation in connection with investigation of a legal claim,

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

The Citizens Commission on Human Rights, Los Angeles Chapter
7671 McGroarty St,
Tujunga, CA 91042

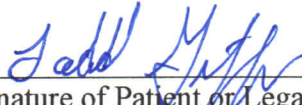


Initials

I understand the following: *See CFR § 164.50(c)(2)(i-iii)*

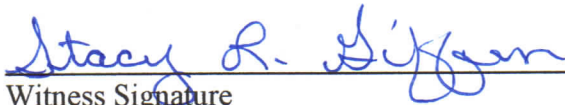
- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.


Signature of Patient or Legally Authorized Representative
(*See 45CFR § 164.508 (~cxl) (vi)*)

4/28/2014
Date

Name and Relationship of Legally Authorized Representative to Patient
(*See 45CFR § 164.508 (cx 1)(iv)*)


Witness Signature

4-28-2014
Date



CITIZENS COMMISSION ON HUMAN RIGHTS®

Established in 1969 by the Church of Scientology® to investigate and expose psychiatric violations of human rights.

LOS ANGELES CHAPTER

General Release Form

I do hereby authorize the Citizens Commission on Human Rights (CCHR) to utilize my name and the information that I have provided to CCHR - its representatives, agents, or employees - regarding my knowledge of psychiatric abuses in the name of mental treatment and any other factual information or documentation provided by myself or other persons, in presentations to government agencies and information packets or news releases for the media, in order to establish the existence of the particular abusive situations within the psychiatric profession which my case represents and to seek reforms of these situations. This would apply to any information that I have not specifically requested in writing to be held confidential.

This information or documentation (referred to above) would include but not be limited to: recorded interviews, photographs, letters, and copies or photostats of medical and/or psychiatric records pertaining to examinations, treatments, or consultations including, but not limited to, admissions and discharge reports, medical and psychiatric history, laboratory findings, x-rays, medication, records, billing records, ward charts, ward and nurses' notes, dietary information, and all medical reports.

I recognize that CCHR is a social reform organization whose purpose is to investigate and expose psychiatric violations of human rights.

4/28/2014
Date

Josh Giffen
Signed

Date

Signed (Parent/Guardian if needed)

4-28-2014
Date:

Stacy L. Giffen
Witness

4/28/14
Date

Jason C. Seaburn
Witness

1989 Riverside Dr, Suite 6, Los Angeles, CA 90039

Telephone 323-663-2247 FAX 323-667-0115

To report psychiatric abuse or fraud, call (800) 942-2247

Declaration of Intention

I, Todd Giffen, born on 3/13/1985
in Stanislaus County, living this date at
3921 Weston Way, Modesto, CA 95356, being of sound mind,
willfully and voluntarily make known my desire that should it be so considered or decided
that I be subject to involuntary incarceration or hospitalization (also known as committal
and certification) in a psychiatric hospital, ward, facility, home or nursing home, and/or
that I be subject to psychiatric procedures including, but not limited to, any form of
psychosurgical or neurological operation such as lobotomy or leucotomy, electro-convulsive
treatment (also known as electroshock or shock treatment or ECT), psychotropic drugs
(including benzodiazepines, major tranquilizers, antidepressants, barbiturates or
neuroleptics generally), deep sleep treatment (narcosis, narcosynthesis, sleep therapy,
prolonged narcosis, modified narcosis or neuroleptization), sterilization, insulin shock or
any other physical based psychiatric or psychological treatment or practice; I direct that
such incarceration, hospitalization, treatment or procedures not be imposed, committed or
used on me.

I refuse contact with and treatment by any psychiatrist, psychologist or other mental health
practitioner as these practices, according to my philosophic and/or religious convictions, do
not adequately or properly diagnose and such diagnoses as are given can constitute a false
accusation about my behavior and/or beliefs and practices, and are stigmatizing and
therefore a threat to my reputation and physical and mental well-being. Any of their
treatments, given against my express wish, are an intrusion upon and thus an assault on my
body and constitute, in my view, criminal assault. Any involuntary hospitalization or
commitment is a violation of my right to liberty and would therefore constitute a false
imprisonment by all those advocating and authorizing such action against my consent and
wishes. If in the future, I am accused of a crime, then I direct that I be subjected to due
process as accorded to the criminally accused and not subjected to psychiatric or
psychological assessment, processing, profile, confinement or treatments.

Among other situations, the above directions and positions apply in any case where my
capacity or ability to give instructions may be or may be claimed to be impaired, or should I
be in a state of unconsciousness, or should my communication in an actual and legal sense
be impossible, or where any psychiatrist, psychologist, mental health practitioner, or law
enforcement official or person asserts that the matter is a "life-saving" situation requiring
emergency intervention and/or treatment under any involuntary commitment law or
similar legal authority.

In the absence of my ability to give further directions regarding the above, it is my intention
that this declaration be honored by my family and physician(s) as an expression of my legal
right to refuse medical, psychological, psychiatric or surgical treatment.

The attorney(s) and other person(s) mentioned below are appointed and authorized to
institute appropriate proceedings on my behalf should the above declaration be violated,

Declaration of Intention:

Page 2

and have my permission herewith to proceed with whatever criminal and/or civil procedures necessary to rectify such a violation.

I herewith authorize the following attorney(s) and other person(s) with the enforcement of this declaration of intention:

Doug Crowder, Gary Brown, Attorney at Law,
any Representative of Citizens Commission on Human Rights,

as well as any person who discovers this document on my person or in my home or elsewhere.

All medical doctors and their organizations as well as therapists are expressly released from their professional discretion or confidentiality towards provision of information to the above named attorney(s) and other person(s).

This declaration is also binding for my lawful agents, guardians, family, executors or any person with the legal or other right to take care of me or my affairs.

Jodee Giffen
Signed

4/28/2014
Date

Phone: 503-967-5202 Web: okamas weapon.com

Stacy L. Giffen
Signature of Witness

Stacy L. Giffen
Printed Name of Witness

Jason C. Seales
Signature of Witness

JASON SEALES
Printed Name of Witness