M E D I C A L R E L E A S E F O R M

For use by
COUNTY OF SANTA CRUZ
DEPARTMENT OF CHILD SUPPORT SERVICES
P.O. BOX 1841, SANTA CRUZ, CA 95061 (866) 901-3212 Fax: (831) 454-3752

SECTION I: PATIENT/CLIENT INFORMATION AND MEDICAL RELEASE

DCSS CASE #: _____ SUPERIOR COURT CASE #: _____

NAME OF PATIENT: _____ BIRTHDATE: _____
Last, First MI

SOCIAL SECURITY #: _____

I authorize _____ or _____
Name of Physician or Psychologist *Name of Clinic or Medical Group*

to release any medical information on this form to the Santa Cruz County Department of Child Support Services. This authorization is valid for one year from the date of signature.

_____ _____
Patient Signature *Date*

SECTION II: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST INSTRUCTIONS

The above-named person has a medical condition that prevents or limits participation in work activities. Participation activities may include full time or part time employment, job training, or other related activities. Please provide the following information about the patient's medical condition, limitations, and any other accommodations needed for the patient to engage in activities that will improve his/her employability. If you need additional space, please use another sheet of paper and attach it to this form.

PLEASE COMPLETE AND RETURN THIS FORM IN THE ATTACHED ENVELOPE TO:

Santa Cruz County
Department of Child Support Services
PO Box 1841
Santa Cruz, CA 95061

SECTION III: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST STATEMENT

1. Please indicate if the patient is able to:
   - ☐ Work full time with no limitations
   - ☐ Work full time with limitations
     Explain: _____
     _____
     _____
   - ☐ Work part time up to _____ hours per day. Date patient may return to full time ___/___/___
   - ☐ Participate in a job training program. Please list any limitations:_____
     _____

2. Please list any accomodations needed for the patient to work or participate in a training program:
   _____
   _____
   _____

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SECTION III: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST STATEMENT Continued

3. If the patient is currently unable to work or participate in a training program, please indicate when the patient is expected to be released to work or training: ___/___/___

4. Please list the diagnosis and prognosis for this patient: _____
   _____
   _____

5. Other comments: _____
   _____
   _____

6. Date of Last Examination: ___/___/___ Next Appointment: ___/___/___

SECTION IV: PHYSICIAN OR PSYCHOLOGIST CERTIFICATION

I understand that statements I have made on this form are subject to verification and investigation.
I declare under penalty of perjury under the laws of the United States and the State of California that the information contained on this form is true, correct and complete.

_____ _____
Signature of Physician, Psychologist, or Person Authorized to Complete this Form *Date*

Address of Office/Clinic:	Phone: