

# MEDICAL RELEASE FORM

For use by  
COUNTY OF SANTA CRUZ  
**DEPARTMENT OF CHILD SUPPORT SERVICES**  
P.O. BOX 50000 Watsonville 95077 (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 50000  
Watsonville, CA 95077**

## 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 accommodations needed for the patient to work or participate in a training program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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*

\_\_\_\_\_  
*Printed Name of Person Completing Form*

Address of Office/Clinic: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_  
\_\_\_\_\_