Print Form

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN MATEO
FAMILY COURT SERVICES
400 County Center, 6th Floor
Redwood City, CA 94063-1668
Tel. (650) 261-5080 - Fax (650) 261-5142
www.sanmateo.courts.ca.gov

AUTHORIZATION FOR RELEASE OF RECORDS AND PROTECTED HEALTH INFORMATION

Completion of this document authorizes the release of health information and other records as set forth below, consistent with California and Federal law concerning the privacy of such information**. Failure to provide *all* information requested may invalidate this authorization.**

To: _____

From Child Custody Recommending Counsel, _____

Parent's Name:_____ Date of Birth: _____

Parent's Name:_____ Date of Birth:_____

I authorize the release of health and other information to Family Court Services from the above person/organization regarding myself and/or my minor children below:

Name of Child:_____ Date of Birth: _____

Name of Child:_____ Date of Birth: _____

Name of Child:_____ Date of Birth: _____

This authorization applies to the following health information and other records (select *only one* of the following):

☐ All health information pertaining to any medical history, mental or physical condition and treatment received, including drug/alcohol and/or HIV/AIDS, psychological and/or psychiatric diagnostic evaluation.
☐ Only the following records or types of health information (including any dates):_____

This authorization also applies to the following information (select *all* that applies):

☐ Educational
☐ Investigative narratives from Child Protective Services

I understand that the released records are to be used by the Family Court Services Child Custody Recommending Counselor to assist my family and myself in making recommendations to the Superior Court about the custody and/or visitation of my child(ren). I understand that I am responsible for any fees regarding this request. The records may be released in writing and/or verbally, as requested by Family Court Services. This authorization shall be valid for a one-year period from the date signed, unless consent is withdrawn in writing.

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my protected health information and other records unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I may refuse to sign this authorization. I may inspect or obtain a copy of the protected health information and other records that I am being asked to release/disclose. I have a right to receive a copy of this authorization. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Family Court Services, 400 County Center, 6th Fl., Redwood City, CA 94063-1668. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

Signature: _____ _____ _____
Person Authorizing Release | Relationship | Date

Signature: _____ _____ _____
Person Authorizing Release | Relationship | Date

A Superior Court hearing (☐) has been set for_____/ (☐) has not been set.

We would appreciate having the records/information by_____. If any fees regarding this request should arise, please inform Family Court Services prior to sending the requested information.

Print Name: _____Signature: _____ _____
Child Custody Recommending Counselor | Date