Print Form

Superior Court of California
County of Trinity

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(FULL NAME), GIVE MY PERMISSION TO RELEASE ANY AND ALL RECORDS RELATED TO MEDICAL, COUNSELING OR PSYCHOLOGICAL SERVICES, CHILD PROTECTIVE SERVICES, POLICE/SHERIFF'S REPORTS, OR SCHOOL RECORDS, TO BE REVIEWED BY **SYLVIA GREEN, MSW,** AND/OR FAMILY COURT SERVICES STAFF UPON THEIR REQUEST. I ALSO GIVE MY PERMISSION TO DISCUSS ANY INFORMATION PERTAINING TO MY CASE. I UNDERSTAND THAT THIS RELEASE IS EFFECTIVE FOR ONE YEAR AND WILL EXPIRE ONE YEAR FROM THE DATE IT IS SIGNED.

(PRINT FULL NAME): _____

(SIGNATURE): _____ DATE: _____

WITNESS: _____ DATE: _____

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