Superior Court of California
County of Trinity

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, GIVE MY PERMISSION TO
(FULL NAME)

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 **STACY BURGESS, MEd** 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 A YEAR FROM THE DATE IT IS SIGNED.

_____
(PRINT FULL NAME)

_____ DATE:_____
(SIGNATURE)

WITNESS:_____ DATE:_____

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