

REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

DCSS 0644 (06/05/09)

I, _____, authorize the Department of Child Support Services to discuss my case information with the person or agency designated below.

I authorize _____ to discuss and/or examine all files, applications, papers, documents and records held by the California Department of Child Support Services or any Local Child Support Agency regarding the establishment of paternity; and the establishment, modification or enforcement of child, medical or spousal support in my case which I am authorized to discuss and/or examine, consistent with Title 22 California Code of Regulations § 111440 and Family Code section 17212.

I am not aware of any court issued protective order, nor a good cause claim under Section 11477.04 of the Welfare and Institutions Code pending or approved by an administrative agency in this case which bars the authorized person or agency named below from access to this information. I further declare that I have no reason to believe that the release of this information to the authorized person or agency named below may result in physical or emotional harm to the child(ren) involved in this case.

This authorization shall expire on _____. I understand that if I wish to revoke this authorization at any time before the expiration date, I must submit a written notification of revocation to the California Department of Child Support Services or any Local Child Support Agency.

In the interest of protecting your personal information, the California Department of Child Support Services encourages you to complete the information requested below. Please provide a copy of this form to your authorized person or agency so they have the information necessary to conduct business on your behalf. If we are unable to identify you or your authorized person or agency from the information provided we may need to contact you.

CHILD SUPPORT PARTICIPANT INFORMATION

Participant's Name (Please Print)	Telephone Number	CSE Case Number	
Address, City, State, and Zip Code		SSN (last four digits)	Date of Birth

AUTHORIZED PERSON INFORMATION

Authorized Person's Name (Please Print)	Telephone Number	SSN (last four digits) or CA ID Number	
Text			
Address, City, State, and Zip Code			

AUTHORIZED AGENCY INFORMATION

Authorized Agency's Name (Please Print)	Telephone Number	Primary Contact Name
Address, City, State, and Zip Code		

I declare under penalty of perjury that I the participant authorize the release of information as described above.

PARTICIPANT'S SIGNATURE

DATE

MAIL TO:
Stanislaus County Child Support
P.O. Box 4189
Modesto CA 95352-4189
FAX: (209) 558-3135

DROP OFF: 251 E. Hackett Rd, Modesto CA