COUNTY OF SANTA CRUZ
AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE THESE PERSONS HAVING ANY KNOWLEDGE OR RECORDS OF MY HEALTH:

-Any physician or medical practitioner.
-Any hospital, clinic or other medical related facility.
-Any insurance company.
-Any plan administrator.

TO COPY AND TRANSMIT TO THE MEDICAL OFFICER LISTED BELOW, ANY AND ALL DATA AND RECORDS CONCERNING MY PHYSICAL AND MENTAL HEALTH.

Medical Services Director
Attention: Dr. Kathleen Loughlin
County of Santa Cruz
P.O. Box 962
Santa Cruz, CA 95061

I UNDERSTAND that the County Health Services Agency will use the information to determine my eligibility for employment.

Santa Cruz County may release information about me to any person performing business or legal services for the County in connection with this determination.

I UNDERSTAND AND AGREE that this authorization shall remain in force pending a final determination of my employment status. A photocopy of this authorization is as valid as the original.

_____
Print your name

_____ _____19____
Signature Date

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