MEDICAL INFORMATION VERIFICATION REPORT

DCSS 0020 (01/18/15)

DATE: CASE NUMBER:

INSTRUCTIONS: *This form is designed to be filled out by the patient and the patient's physician or psychologist.*

SECTION I *(Patient Information and Medical Release)**:*** *To be filled out by the patient. The patient is required to return it to the local child support office. The local child support office will then send this form to the patient's physician for completion.*

SECTIONS II, III, and IV: *To be filled out by the patient's physician only.*

SECTION I: PATIENT INFORMATION AND MEDICAL RELEASE

(Pursuant to and in compliance with the Health Insurance Portability and Accountability Act and following regulations in Title 45, Code of Federal Regulations, Part 164.)

Patient Name: _____ Date of Birth: _____

As the patient identified above, I hereby authorize the disclosure and release of my personal health information as follows:

1. I authorize _____
   (NAME OF LICENSED PHYSICIAN OR BOARD CERTIFIED PSYCHOLOGIST)

   _____
   (PHYSICIAN'S OR PSYCHOLOGIST'S ADDRESS, CITY STATE, ZIP CODE)

   to disclose and release my personal and protected health information stated in Section III of this report to the Department of Child Support Services listed in item 2 below.
2. I permit the release of this health information to the VENTURA Department of Child Support Services, that has a duty under Family Code section 17400 to enforce my child support obligations.
3. The purpose of this requested disclosure is described in Section II.
4. This authorization for disclosure of health information expires on _____.
   (SPECIFY DATE)
5. I understand that I have a right to revoke this authorization for disclosure in writing by delivering copies of the revocation to both my health care provider and to the child support agency.
6. I understand that I have a right to receive a copy of this authorization.
7. I understand that the health information disclosed by my health care provider to the child support agency has the potential to be re-disclosed to others and lose its protected status.

Signed on _____, at _____
(SPECIFY MONTH, DAY AND YEAR) (SPECIFY CITY AND STATE)

_____ _____
(PRINT PATIENT'S NAME) (SIGNATURE OF PATIENT)

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SECTION II: INSTRUCTIONS FOR LICENSED PHYSICIANS

VENTURA Department of Child Support Services needs the following information from you to verify that the person whose information is listed on page one is either temporarily, permanently or totally disabled. This means the patient is either temporarily or permanently unable to perform any work at either his or her usual occupation or at any other job that he or she could be trained to do. The purpose of the disclosure requested in Section III is to provide information necessary for the local child support agency to determine the support potential of your patient in case number:

SECTION III: LICENSED PHYSICIANS STATEMENT

1. Is this patient temporarily disabled? ☐ Yes ☐ No
   If Yes, complete items 3-7 and Section IV. If No, complete item 2.
2. Is this patient totally or permanently disabled? ☐ Yes ☐ No
   If Yes, complete items 3-7 and Section IV. If No, complete Section IV.
3. Onset date for this disability: _____
4. List diagnosis and prognosis for this patient: _____
5. Treatment Plan: _____
6. Date of last examination: _____
7. When do you expect this patient to be able to return to work? _____

SECTION IV: LICENSED PHYSICIAN CERTIFICATION

I declare under penalty of perjury under the laws of the State of California that the information contained in this report is true, correct, and complete.

_____ _____
(SIGNATURE OF PHYSICIAN OR PSYCHOLOGIST) (DATE)

_____ _____
(PRINT NAME) (TELEPHONE NUMBER)

_____ _____ _____ _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)