ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):	*FOR COURT USE ONLY*
TELEPHONE NO.: FAX NO.(Optional): EMAIL ADDRESS (Optional): ATTORNEY FOR (Name):	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO ☐ CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101 ☐ EAST COUNTY DIVISION, 250 E. MAIN ST., EL CAJON, CA 92020 ☐ SOUTH COUNTY DIVISION, 500 3RD AVE., CHULA VISTA, CA 91910 ☐ NORTH COUNTY DIVISION, 325 S. MELROSE DR., VISTA, CA 92081	
PLAINTIFF(S)/ PETITIONER(S)	
DEFENDANT(S)/ RESPONDENT(S)	CASE NUMBER
VERIFICATION OF DISABILITY (CONFIDENTIAL)	DCSS NUMBER

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

I hereby authorize my doctor and/or my doctor's designee to release medical information necessary to complete the Verification of Disability portion of this form set forth below. The purpose of this authorization is so that appropriate child and/or spousal support may be determined in my case(s).

Date: _____ Patient Signature: _____

Verification of Disability by Doctor

The nature of the patient's disability/injury that limits his/her employment is: _____

_____.

The patient is under my care and has been since _____.

The patient ☐ cannot work ☐ can work with the following limitations: _____

_____.

The patient should be able to return to work on _____.

The patient's next scheduled appointment with me is _____

I declare under penalty of perjury pursuant to the laws of the State of California that the above is true and correct.

Date: _____ Signature: _____

Printed Name and Title: _____

Address: _____

Telephone Number: _____

Medical License Number: _____

Clear This Form