

AUTHORIZATION FOR **APPEAL**  
(TO RELEASE CONFIDENTIAL INFORMATION)

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Print)

Address \_\_\_\_\_ City \_\_\_\_\_ CA ZIP \_\_\_\_\_

Daytime Telephone(s): \_\_\_\_\_ Position for which applied:

( ) \_\_\_\_\_ Deputy Sheriff Trainee

( ) \_\_\_\_\_ Other Position: \_\_\_\_\_  
(Please Specify)

Date of oral psychological evaluation: \_\_\_\_\_ Date of Disqualification Letter \_\_\_\_\_

Location: \_\_\_\_\_ Los Alamitos \_\_\_\_\_ Encino \_\_\_\_\_ West L.A.  
\_\_\_\_\_ Other Location: \_\_\_\_\_  
\_\_\_\_\_

Name of County contract psychologist (if known): \_\_\_\_\_

***I hereby authorize the County contracted psychologist to release the records of my pre-employment psychological evaluation, or a photocopy thereof, to the Chief of Psychological Services, Occupational Health Programs. The purpose and use of the records shall be for consideration in my appeal of disqualification.***

***I further authorize the Chief of Psychological Services, Occupational Health Programs, to prepare and send a copy of the pre-employment psychological evaluation records to the evaluator below:***

\_\_\_\_\_  
Name of Independent Evaluator

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

***The purpose and use of the copy of records by the independent evaluator I have selected shall be for consideration, together with direct assessment, in forming an opinion of my suitability to occupy the position, indicated above, from which I have been disqualified.***

Send completed Authorization to: Chief of Psychological Services  
Occupational Health Programs  
3333 Wilshire Blvd., Suite 1000  
Los Angeles, CA 90010  
Phone: (213) 738-4200 Fax: (213) 637-0822

Signer may revoke this authorization at any time except for action already taken that relied on the authorization. Signer may revoke the authorization by notifying in writing the Chief of Psychological Services, Occupational Health Programs, and the County contract psychologist indicated above. Unless so revoked, the authorization will expire one year from the date of signature, below. Occupational Health Programs will not further disclose information obtained pursuant to the authorization, except by order of a court or other lawful authority. Signer is advised, however, that information disclosed by Occupational Health Programs has the potential to be redisclosed by the recipient unless otherwise restricted from such redisclosure. A photocopy of this authorization is as valid as the original. Signer may prepare and retain a copy of this authorization or request a copy from Occupational Health Programs.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_