

AUTHORIZATION TO **REVIEW**
(TO RELEASE CONFIDENTIAL INFORMATION)

Name: _____ SSN: _____ 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 a review of my disqualification.

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. 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: _____