



**Superior Court of California
County of Trinity**

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, GIVE MY PERMISSION TO
(FULL NAME)

RELEASE ANY AND ALL RECORDS, RELATED TO MEDICAL,

COUNSELING OR PSYCHOLOGICAL SERVICES, CHILD

PROTECTIVE SERVICES, POLICE/SHERIFF'S REPORTS, OR

SCHOOL RECORDS, TO BE REVIEWED BY **SYLVIA GREEN, MSW** and/or

FAMILY COURT SERVICES STAFF UPON THEIR REQUEST. I ALSO

GIVE MY PERMISSION TO DISCUSS ANY INFORMATION PERTAINING

TO MY CASE. I UNDERSTAND THAT THIS RELEASE IS EFFECTIVE FOR ONE YEAR,

AND WILL EXPIRE A YEAR FROM THE DATE IT IS SIGNED.

(PRINT FULL NAME)

(SIGNATURE)

DATE: _____

WITNESS: _____

DATE: _____