County of Los Angeles
Department of Human Resources
Occupational Health Programs
Counseling and Evaluation Section
3333 Wilshire Boulevard, Suite 1000, Los Angeles, California 90010
(213) 738-4200 • Fax (213) 637-0822

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

Name:_____ SS#:_____ DOB:_____
(Print)
Address_____ City_____ CA, ZIP_____

Daytime Telephone(s):

( ) _____

( ) _____

Position for which you were disqualified:

_____

Date of Disqualification Letter: _____

Date of oral psychological evaluation: _____

Psychologist: _____ Dr. Saxe-Clifford _____ Dr. Shaffer _____ Dr. Gallivan

_____ Other Psychologist: _____

I hereby authorize the above 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 of the above-mentioned position.

Send completed Authorization to:

County of Los Angeles
Department. of Human Resources
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 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: _____