Court Case #_____ CSE#_____

CERTIFICATION TO RETURN TO WORK: TO BE COMPLETED BY M.D.

Pursuant to and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and following regulations in Title 45, Code of Federal Regulations, Part 164,
I _____ authorize the disclosure and release of my personal health information by the doctor named below to the Santa Clara County Department of Child Support Services.

_____ _____
Date Signature of Patient

Physician Name: _____M.D.

Phone #_____ Fax #_____

Patient Name: _____has been under my care from _____to_____

Patient was seen for:_____

_____

Diagnosis/Remarks: _____

_____

How long has Patient had this disability? _____

Medications: _____

Treatment Plan: _____

Does Patient have any work limitations? Y N

If yes, describe: _____

Will Patient be able to return to work? Y N If yes, on what date? _____ Full or Part Time?

With this disability, is the Patient able to operate a motor vehicle?_____

I declare, under penalty of perjury under the laws of the State of California that the information contained in this report is true, correct and complete.

_____M.D. License #_____ Date _____

(Physician's Signature)

Rev 6/9/14 djp