



JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

Authorization for Release of Information in Connection with J-1
Visa Waiver Application
By California Department of Health Care Services

My full name is: _____

I am completing this authorization on my own behalf as an individual. By signing below, I acknowledge that I understand my privacy rights in information submitted in connection with my J-1 Visa Waiver application (Application) in the possession of the California Department of Health Care Services (Department). Specifically, I understand that some information in the Department's possession in connection with the Application would not normally be disclosed to persons other than myself by the Department. I also understand that the Department might not routinely release information regarding the status of my Application and/or specific information regarding the Application to persons other than myself.

I hereby authorize the Department to release confidential material related to my Application and to whether it is granted or denied to the following persons, and to those persons' duly appointed employees or staff within the scope of their duties, to the same extent that the Department would release such information to me. This authorization is only valid for 30 days from the date of signature, in conformance with California Civil Code, section 1798.24, subdivision (b).

Name of Recipients:

Signature: _____ Date: _____