



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



Authorization for Release of Information Regarding the J-1 Visa Waiver Application By California Department of Health Care Services

Name of Applicant: _____

I have completed this authorization on my behalf as an applicant for a J-1 Visa Waiver. By signing below, I acknowledge that I understand my privacy rights in connection with the J-1 Visa Waiver application (Application) submitted to the California Department of Health Care Services (Department). Specifically, I understand that the Department may disclose my information to recipients other than me, for the purpose of evaluating this Application.

I hereby authorize the Department to release confidential information contained in my Application to the United States Department of State (DOS). This authorization specifically applies to DOS Case Number _____, and is valid through the final disposition of this Application. If the DOS Case Number is not specified, then this authorization is valid for only 30 days from the date of applicant's signature, in conformance with California Civil Code, section 1798.24, subdivision (b).

Name of Recipient(s): _____

Applicant's Signature: _____ Date: _____