AUTHORIZATION FOR COLLATERAL CONTACT RELEASE OF INFORMATION

Child Custody Evaluation / CCRC and (Family Code §3111)

County and Case Number: _____

Parent Authorizing Release: _____

Child(ren): _____

I authorize:

Joel D. Walton, M.A., LMFT
7844 Madison Ave., Suite 108
Fair Oaks, CA 95628

to request, obtain, and exchange information with the following individual:

Name of Collateral Contact: _____

Title/Relationship: _____

Agency (if applicable): _____

Phone/Email (if known): _____

Purpose of Contact

☐ Court-Ordered Child Custody Evaluation pursuant to Family Code §3111

☐ Child Custody Recommending Counseling (CCRC)

☐ Private Custody Evaluation

This authorization is solely for purposes of completing the above-referenced custody matter and assessing the best interests of the child(ren).

Scope of Information

This authorization permits the exchange of verbal and written information reasonably related to:

• Parenting capacity
• Co-parenting functioning
• The child's safety, welfare, and best interests

This may include medical, mental health, educational, prior evaluation, or other relevant information.

Acknowledgments

I understand:

• This is a forensic process and not confidential therapy.
• Information obtained may be summarized or included in written reports or oral recommendations to the Court.
• I may revoke this authorization in writing prior to disclosure.
• Revocation does not apply to information already obtained.

Expiration

This authorization expires upon completion of the evaluation/CCRC process or two (2) years from the date signed, whichever occurs first, unless revoked earlier in writing.

Signature: _____ Date: _____

Printed Name: _____