In the Court of Common Pleas of Lawrence **County, Pennsylvania**

Phone: 724-656-2122 **Fax:** 724-658-7851

Plaintiff Name:
Defendant Name:
Docket Number:
PACSES Case Number:
Other State ID Number:
Please note: All correspondence must include the PACSES Case Number.

Authorization to Obtain and Use Personal Information

I understand that the Domestic Relations Section (DRS) of Lawrence County Court of Common Pleas and the Commonwealth of Pennsylvania, Department of Human Services (DHS), may obtain and use any information including, but not limited to, my age, residence, citizenship, employment, applications for employment, income, resources, protected health information and school records in accordance with Title 45 of the Code of Federal Regulations 5b.9 and 164.306 and Title 23 of the Pennsylvania Consolidated Statutes §4305(a)(10). I understand that the information obtained will be used for purposes directly related to my support case.

I understand that Lawrence County DRS and the Commonwealth of Pennsylvania, DHS, reserve the right to change privacy practices and will mail a copy of any revised notice to the address I have provided. I understand that I may inspect or copy my personal health information.

Witness	Signature	Date

Title

Service Type

Worker ID

In the Court of Common Pleas of Lawrence **County, Pennsylvania**

Phone: 724-656-2122 **Fax:** 724-658-7851

Member Name:
Docket Number:
PACSES Case Number:
Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

PHYSICIAN VERIFICATION FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN:

Physician's Name: _____

Physician's License Number: _____

Nature of patient's sickness or injury:

_____

_____

_____

(a) Date of first treatment: _____

(b) Date of most recent treatment: _____

(c) Frequency of treatments: _____

(d) Medication: _____

The patient has had a medical condition that affects his or her ability to earn income from:

_____ through _____

If the patient is unable to work, when should the patient be able to return to work? Will there be limitations?

_____

_____

REMARKS: _____

_____

Date: _____ Signed: _____
Signature of Treating Physician

I authorize my physician to release the above information to the County Domestic Relations Section.

_____
Physician's Address

_____

_____
Physician's Telephone Number

_____ _____
Patient's Signature **Date**

Form EN-015 09/17

Service Type

Worker ID