A Public Service Agency

CONFIDENTIAL

MEDICAL INFORMATION AUTHORIZATION
(Name and Gender Change)

TO (HOSPITAL OR MEDICAL FACILITY)	DATED (VALID FOR THREE YEARS FROM THIS DATE)
ADDRESS	DRIVER LICENSE NO.
	CASE NO. (MEDICAL)
	SOCIAL SECURITY NO.
TO (PHYSICIAN)	PHONE NUMBERS (IF AVAILABLE)
ADDRESS	Patient (Preferred Name)
	Physician
	Hospital

PERSON'S PRESENT NAME AND DATE OF BIRTH (SHOWN ON DRIVER'S LICENSE OR ID CARD)

TO BE COMPLETED BY MEDICAL DOCTOR OR HOSPITAL.

My professional opinion is that the person's:

Gender Identification is ☐ Male ☐ Female (On this date ________________)

Demeanor is ☐ Male ☐ Female (On this date ________________)

Gender Identification checked above is: ________________ ☐ Complete ☐ Transitional (Please comment.)

Comments: ____

____

____

ADVISORY STATEMENT

Medical information is required under the authority of Divisions 6 and 7 of the California Vehicle Code. Failure to provide the information is cause for refusal to issue a license, or to cancel or withdraw the driving privilege.

All records of the department relating to the physical or mental condition of any person are confidential and not open to public inspection (Section 1808.5, California Vehicle Code).

AGREEMENT

I hereby authorize my physician or hospital to answer the above questions and submit information to the Department of Motor Vehicles, or its employees, relating to my gender identification for the purpose of obtaining a driver license or identification card under my preferred gender.

I understand that information received by the department will be held in the strictest confidence per Vehicle Code 1808.5 unless I authorize an attorney to gain access to my file. Any expense involved is to be charged to me and not to the Department of Motor Vehicles.

ATTN: Physician or Hospital—Please return this form to the subject for inclusion with the driver license or identification card application.

Signed: ______________________________ ______________________________
WITNESS

A completed examination form for this person is on file in my office at:

ADDRESS
DATE OF EXAMINATION
NAME OF EXAMINING PHYSICIAN/MEDICAL LIC. NO.
SIGNATURE OF PHYSICIAN

DMV Examiner's Signature ______________________________

D.M.V.