

ATTORNEY OR PARTY WITHOUT ATTORNEY (<i>Name, State Bar number, and address</i>): TELEPHONE NO.: _____ FAX NO. (<i>Optional</i>): _____ E-MAIL ADDRESS (<i>Optional</i>): _____ ATTORNEY FOR (<i>Name</i>): _____	FOR COURT USE ONLY
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (<i>Name</i>): _____ <p style="text-align: center;">PROPOSED CONSERVATEE</p>	CASE NUMBER: CONSERVATORSHIP PETITION HEARING DATE:
EX PARTE APPLICATION FOR ORDER AUTHORIZING COMPLETION OF CAPACITY DECLARATION—HIPAA * (Health Insurance Portability and Accountability Act of 1996)	DEPT.: _____ TIME: _____

1. Applicant (*name*):
 has filed a petition for the appointment of a conservator for the above-named proposed conservatee. The petition is set for hearing on (*date*): _____ at (*time*): _____ in Dept.: Rm.:
2. The petition requests (*check all that apply*):
 - a. A finding that the proposed conservatee should be excused from attending the hearing on the petition.
 - b. Exclusive authority to consent to medical treatment for the proposed conservatee.
 - c. Dementia powers.
 - d. Appointment of a conservator of the estate.
 - e. Other (*specify*): _____
3. Applicant has requested (*name each declarant*):

to complete, sign, and deliver to applicant for use to support the petition, a *Capacity Declaration—Conservatorship* (form GC-335) *Dementia Attachment to Capacity Declaration—Conservatorship* (form GC-335A) (the Declaration), concerning the medical condition or mental capacity of (*name of proposed conservatee*):

4. The proposed conservatee has not consented to the disclosure of any private medical information that would be disclosed by the completed Declaration.
5. Applicant requests this court to authorize each declarant named in item 3 to complete, sign, and deliver the Declaration to Applicant within 15 days of the declarant's receipt of the court's order.
6. Applicant requests this court to dispense with notice of hearing on this application.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

_____ _____
 (TYPE OR PRINT APPLICANT'S NAME) (APPLICANT'S SIGNATURE)

* For use with *Ex Parte Order Re Completion of Capacity Declaration—HIPAA* (form GC-334).