ATTORNEY OR PARTY WITHOUT ATTORNEY STATE BAR NUMBER: NAME: FIRM NAME: STREET ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE NO.: FAX NO.: E-MAIL ADDRESS: ATTORNEY FOR *(name):*	*FOR COURT USE ONLY*
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name):* PROPOSED CONSERVATEE	CASE NUMBER:
	CONSERVATORSHIP PETITION HEARING DATE:
EX PARTE APPLICATION FOR ORDER AUTHORIZING COMPLETION OF CAPACITY DECLARATION—HIPAA*	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. ☐ Authority to make placement or medication decisions related to a major neurocognitive disorder (such as dementia).
   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)
   ☐ and a *Major Neurocognitive Disorder 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)

* The federal Health Insurance Portability and Accountability Act of 1996. Use this form with *Ex Parte Order Re Completion of Capacity Declaration—HIPAA* (form GC-334).

Form Adopted for Mandatory Use
Judicial Council of California
GC-333 [Rev. January 1, 2019]

Probate Code, §§ 1220, 1825, 1890, 1893, 2356.5;
42 U.S.C. §§ 1177, 1178;
45 C.F.R. §§ 160, 164
www.courts.ca.gov

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