

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH  
PATIENTS' RIGHTS OFFICE**

**Confidential Client Information: Welfare and Institutions Code 5328**

**BENEFICIARY/CLIENT GRIEVANCE OR APPEAL AND  
AUTHORIZATION FORM**

**You may file a GRIEVANCE at any time.  
You may authorize another person to act on your behalf.**

**You have the right to file an APPEAL with the Patients' Rights Office  
or to request a State Fair Hearing when the Local Mental Health Plan:**

- 1. Denies or limits authorization of a requested service;**
- 2. Reduces, suspends, or terminates a previously authorized service;**
- 3. Denies, in whole or in part, payment for a service;**
- 4. Fails to provide services in a timely manner; or**
- 5. Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.**

**Only clients who are Medi-Cal recipients may request a State Fair Hearing.**

**Person Filing the Grievance or Appeal**

LAST NAME	FIRST NAME	M.I.	BIRTH DATE	MEDI-CAL #

ADDRESS	CITY	STATE	ZIP	HOME PHONE

**Grievance or Appeal Filed Against**

NAME OF FACILITY/PROVIDER/PROGRAM	PHONE

ADDRESS	CITY	STATE	ZIP CODE



**BENEFICIARY/CLIENT GRIEVANCE/APPEAL & AUTHORIZATION  
FORM (Continued)**

**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH  
INFORMATION:**

If you sign this document, you give permission to the Los Angeles County – Department of Mental Health, Patients’ Rights Office to investigate your grievance or appeal. This Authorization will allow your health care providers to disclose the following health information to Los Angeles County – Department of Mental Health, Patients’ Rights Office to investigate your grievance or appeal:

- Your past and current medical records; and
- Other information relating to your grievance or appeal and/or denial or rights.

**Expiration Date:**

This Authorization will expire on the date of the resolution of your grievance or appeal.

**Your Rights Regarding This Authorization:**

If you agree to sign this Authorization, you must be provided with a signed copy of this form.

You do not have to sign this Authorization, and your refusal will not affect your ability to obtain treatment.

You can revoke or cancel your Authorization to allow use of your health information at any time by telling Los Angeles County – Department of Mental Health in writing. You must sign your revocation request and mail or deliver it to:

County of Los Angeles – Department of Mental Health  
Patients’ Rights Office  
550 South Vermont Avenue  
Los Angeles, CA 90020

If you revoke this Authorization, we may still use and share your health information that has already been obtained for reasons related to prior reliance of this Authorization.

**BENEFICIARY/CLIENT GRIEVANCE/APPEAL & AUTHORIZATION**  
**FORM (Continued)**

**Authorization Approval:** By signing this form, I authorize the use or disclosure of the health information described above. I understand that my health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed unless another authorization is received from me or such use or disclosure is specifically permitted or required by law.

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**Signature of Client/Client's Representative**

**Date**

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**If signed by client's personal representative,  
state relationship and authority to do so.**

**YOU HAVE THE RIGHT TO FREE LANGUAGE ASSISTANCE SERVICE.**

**CALL THE PATIENTS' RIGHTS OFFICE FOR ASSISTANCE AT:**

**NON-HOSPITAL GRIEVANCES/APPEALS- (213) 738-4949**

**HOSPITAL GRIEVANCES/APPEALS - (800) 700-9996 or (213) 738-4888**

- ◆ Did you complete the information requested on the form?
- ◆ Did you list your phone number and address where we can contact you?
- ◆ Did you sign both the grievance or appeal section on page 2 and the authorization section on this page?
- ◆ Please mail to:
  - County of Los Angeles – Department of Mental Health**
  - Patients' Rights Office**
  - 550 South Vermont Avenue**
  - Los Angeles, CA 90020**
- ◆ Please don't forget a postage stamp.