LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

ATTACHMENT I
DMH POLICY 310.01

CONSENT FOR RELEASE OF DMH CLINICAL RECORD INFORMATION

I hereby authorize _____
FACILITY OR PROGRAM

to disclose records and/or information regarding _____,
NAME OF PATIENT

date of birth _____ / _____ / _____, obtained in the course of his/her diagnosis and treatment to:

_____ NAME OF REQUESTOR
_____ AGENCY/FACILITY/COMPANY/PHYSICIAN/ATTORNEY

_____
STREET CITY STATE ZIP CODE

This disclosure of records is required for these purpose(s): _____

The information is subject to these limitations: _____

These records are protected by the California Welfare and Institutions Code Section 5328. Disclosure shall be limited to the information specified below *(check appropriate items):*

- ☐ ASSESSMENT/EVALUATION
- ☐ RESULTS OF PSYCHOLOGICAL TESTS
- ☐ DIAGNOSIS
- ☐ TREATMENT
- ☐ MEDICATION HISTORY/CURRENT MEDICATIONS
- ☐ LABORATORY RESULTS
- ☐ HIV TEST RESULTS
- ☐ OTHER: Specify

An additional consent must be obtained for any other record transfer or sensitive information disclosure. I also understand that the requestor may not further use or disclose the medical information unless he/she obtains another authorization from me or unless such use or disclosure is specifically required or permitted by law.

This authorization shall become effective _____ / _____ / _____ and is subject to revocation by the undersigned at any time except to the extent that the action has already been taken. If not earlier revoked, this consent shall terminate on _____ / _____ / _____. (Termination date should not be more than 90 days from effective date unless the treatment plan justifies ongoing communications with the above named agency. Under no circumstances should the termination date exceed one year.)

_____ DATE
_____ SIGNATURE OF PATIENT

_____ WITNESS
_____ SIGNATURE OF PARENT/GUARDIAN/CONSERVATOR/ATTORNEY FOR HEALTH CARE

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION IF I SO REQUEST.

CONSENT REVOKED _____ / _____ / _____ _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN/CONSERVATOR

The undersigned therapist, who is primarily responsible for the treatment of the patient, disapproves in part ☐ or whole ☐ of the requested release of information to the party specified above. If disclosure is disapproved, note below the reason for any partial or complete restriction.

_____

_____ SIGNATURE AND TITLE
_____ DATE

_____ SUPERVISOR/PROGRAM DIRECTOR'S SIGNATURE AND TITLE
_____ DATE