

CLIENT’S REQUEST FOR ACCESS TO HEALTH INFORMATION
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

SIGNATURE OF CLIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE:

If signed by other than client, state relationship and authority to do so:

DATE: ____/____/____
Month Day Year

FORM(S) OF IDENTIFICATION PROVIDED:

___ State Driver’s License _____

___ State Identification Card _____

___ Birth Certificate _____

___ Military ID _____

___ Other (Provide details) _____

FACILITY: _____

PRACTITIONER: _____

DATE: ____/____/____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

Patient’s Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.