



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT CONTACTS WITH THE MEDIA	POLICY NO. 611.3	EFFECTIVE DATE 09/30/03	PAGE 1 of 3
APPROVED BY: <div style="text-align: center; margin-top: 10px;">  Director </div>	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 To ensure timely and appropriate response to media inquiries while protecting information deemed by law to be private and confidential.

POLICY

- 2.1 In accordance with policy established by the Board of Supervisors that supports openness in County government, priority shall be given to requests for public information from the media. Unnecessary delays by Department of Mental Health (DMH) staff in responding to the media should not be imposed by supervisory and/or management staff or by the Public Information Officer.
- 2.2 This policy does not apply to media requests for independent expert opinion and views from staff on matters outside the realm of County business in areas where the staff, by virtue of their training and/or professional discipline, is considered an independent expert.
- 2.3 Only that information defined as "Public Records" in the California State Government Code, Section 6252(d) may be released without consent from affected parties, including clients. These include information related to the conduct of the public's business that are prepared, owned, used or retained by DMH regardless of physical form or characteristic.
 - 2.3.1 DMH staff is not ordinarily required to prepare or develop documents beyond those that already exist nor are they required to prepare analyses of existing documents.
- 2.4 Documents exempt from disclosure under California law include:
 - 2.4.1 Information pertaining to voluntary or involuntary recipients of specified services, including mental health, community mental health, admissions and judicial commitments and mental institutions;
 - 2.4.2 Personnel, medical or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy. (California State Government Code, Section 6254(e));



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- 2.4.3 Certain records relating to test questions, scoring keys and other examination data. (California State Government Code, Section 6254(g)); and
 - 2.4.4 Records pertaining to pending litigation to which DMH is a party, or the work product of an attorney, or information that falls under the attorney-client privilege. (California State Government Code, Sections 6254 and 6254.25)
- 2.5 In the event a person receiving voluntary or involuntary mental health services from DMH or its contractor agencies chooses to participate in responding to media inquiries, staff are required to obtain a prior signed "Consent to Photograph/Audio Record" (Attachment I) as well as a prior signed "Consent for Release of DMH Clinical Record Information" (Attachment II) from the person or his/her legal guardian before endorsing or facilitating such participation.

PROCEDURE

- 3.1 Staff may respond to routine media inquiries regarding issues relevant to DMH operations that are in areas of their expertise but with the consent of their District Chief and/or Deputy Director. Staff are required to consult with the Department's Public Information Officer prior to providing media with any information. Immediately following a response, staff should complete a "Notice of Press Contact" (Attachment III) and fax it to the Public Information Officer. The Public Information Officer will inform the Chief Deputy Director of the reported media contact.
- 3.2 Requests for information outside an individual's area of expertise or of a politically sensitive nature must be referred to the Public Information Officer. DMH personnel shall promptly provide information upon request from the Public Information Officer to enable a timely response. When needed, the Public Information Officer shall work with the Chief Administrative Office's Public Affairs Office and/or County Counsel's Office to determine the propriety of releasing the requested document/information. Items expected to generate considerable and/or controversial media attention will be communicated by the Public Information Officer to the Chief Administrative Office's Public Affairs Office and the Chief Deputy Director.
- 3.3 Following approval by the appropriate District Chief, staff will provide relevant written information needed for all necessary press releases directly to the Public Information Officer to finalize as a press release. The Public Information Officer, in consultation with staff, shall develop a final copy of the press release within five (5) working days of the date the information is received by the Public Information Officer. The Public Information Officer shall distribute the press release to relevant media, after approval by the appropriate Deputy Director.

APPEAL PROCESS

- 4.1 Representatives from the media who believe they have been denied access to a public document may appeal, in writing, to
DMH Chief Deputy Director



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550 S. Vermont Ave., 12th Floor
Los Angeles, CA 90020

The Director of Mental Health is the final appeal authority within the Department. The Board of Supervisors' adopted policy designates the Chief Administrative Office's Public Affairs Office as the Board's representative in resolving disputes between the media and the Department.

AUTHORITY

Board Order No. 94 (April 2, 2002)
California State Government Code Sections 6252(d), 6254(e), 6254(g), and 6254.25
Welfare and Institutions Code, Section 5328

ATTACHMENTS

Attachment I	Consent to Photograph/Audio Record
Attachment II	Consent for Release of DMH Clinical Record Information
Attachment III	Notice of Press Contact

REVIEW DATE

This policy shall be reviewed on or before October 2008.

**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
 CONSENT TO PHOTOGRAPH/AUDIO RECORD**

The undersigned client or responsible party* consents to and authorizes:

_____ to
 Name of Facility and/or Program or Unit and/or Employee Name

_____ photograph (which, as used in this Consent, means motion picture, still photography in any form, videotapes, or any other mechanical means of recording and reproducing images)
 _____ audio record

The undersigned:

1. agrees that photographs/audio recordings made as a result of this consent will be used only by employees of the Department of Mental Health for:
 _____ educating and training _____ research
 _____ publication, public relations and/or fund raising as specified on the next line

except for these limitations: _____

2. waives any right to compensation for use of the photographs/audio recordings;
3. holds the Department harmless from and against any claim of injury or compensation resulting from the activities authorized by this Consent;
4. understands this Consent remains valid unless the client or legal representative withdraws his/her Consent in writing, but that a new Consent will be required for any purpose other than that stated above.

_____ Signature of Client ** Date

_____ Signature of Responsible Party* Relationship to Client Date

_____ Signature of Client Date

* Responsible Party – Guardian, Conservator or Parent of Minor when required.

** A minor patient receiving services under his/her own signature must have the Minor Consent form on file in the clinical record.

Signator [] was given or [] refused a copy of this Consent on _____ by _____
 Date Initials

<p>This confidential information is provided to you in accordance with Welfare and Institutions Code Section.5328. Duplication of this information for further disclosure is prohibited without the prior written consent of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>	<p>Name: _____ MIS # _____ Agency: _____ Los Angeles County Department of Mental Health</p>
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CONSENT TO PHOTOGRAPH/AUDIO RECORD

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

_____ Name of Client/Previous Names	_____ Birth Date	_____ MIS Number
_____ Street Address	_____ City, State, Zip	

AUTHORIZES:

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____ Name of Health Care Provider	_____ Name of Health Care Provider/Plan/Other
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code

INFORMATION TO BE USED OR DISCLOSED:

<input type="checkbox"/> Assessment/Evaluation	<input type="checkbox"/> Results of Psychological Tests	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Medication History/ Current Medications	<input type="checkbox"/> Treatment
<input type="checkbox"/> Entire Record (Justify)	_____	
<input type="checkbox"/> Other (Specify): _____	_____	

PURPOSE OF USE OR DISCLOSURE: (Check applicable categories)

Client's Request
 Other (Specify): _____

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

EXPIRATION DATE: This authorization is valid until the following date: _____ / _____ / _____
Month Day Year

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF CLIENT/LEGAL REP: _____

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

DATE: _____ / _____ / _____
Month Day Year

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION (PHI)**

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

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

DATE: ____ / ____ / ____
 Month Day Year

County of Los Angeles Department of Mental Health

Notice of Press Contact

**FACSIMILE
(DO NOT MAIL. FAX ONLY)**

TO: _____, Public Information Officer

FAX: (213) 386-1297

FROM: _____

PHONE: _____

LOCATION: _____

DATE OF CONTACT: _____

NAME OF MEDIA PERSON: _____

NAME OF MEDIA: _____

PHONE: _____

DATE AND TIME WHEN INFORMATION WILL BE PUBLISHED OR BROADCAST:

Briefly describe the information requested by media and your response (use additional sheets if necessary).