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:

Name of Health Care Provider _____

Street Address _____

City, State, Zip Code _____

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

INFORMATION TO BE USED OR DISCLOSED:

__ Assessment/Evaluation
__ Laboratory Results
__ Entire Record (Justify)
__ Results of Psychological Tests
__ Medication History/ Current Medications
__ Diagnosis
__ Treatment
__ 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 AUTHORIZATON:
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