Clear Entire Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT:

Name of Client/Previous Name | Birth Date | Client Number

Name of Legal Representative (If applicable)

Street Address | City, State ZIP Code

AUTHORIZES:

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Name of Agency | Name of Health Care Provider/Other

Street Address | Street Address

City, State ZIP Code | City, State ZIP Code

INFORMATION TO BE RELEASED:

☐ Assessment/Evaluation ☐ Psychological Test Results ☐ Diagnosis
☐ Laboratory Results ☐ Medication History/Current Medication ☐ Treatment
☐ Entire Record (Justify): _____
☐ Other (Specify): _____

NOTE: Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested.

Check all that apply: ☐ Alcohol or Drug Records ☐ HIV Test Results

Method of delivery of requested records:
☐ Mail ☐ Pickup ☐ Electronic Device (CD, USB)

PURPOSE OF USE OR DISCLOSURE: (Check applicable category)

☐ Client Request
☐ Other (Specify): _____

Will the agency receive any benefits for the use or disclosure of information? ☐ Yes ☐ No

I understand that my Protected Health Information used or disclosed pursuant to this Authorization may no longer be protected by federal law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is used or disclosed, it may not be possible to recall.

EXPIRATION DATE: This Authorization is valid until _____ / _____ / _____.
Month Day Year

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of 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 Authorization - I understand that I have the right to revoke this Authorization at any time by notifying LACDMH in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to:

Contact Person	Agency Name
Address	City, State ZIP Code

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

Conditions: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, LACDMH 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 Representative	Date

If signed by someone other than the client, state relationship and authority:

✘

REVOCATION OF AUTHORIZATION

Name of Client

Signature of Client/Legal Representative	Date

If signed by someone other than the client, print name and state relationship and authority.

Printed Name: _____

Relationship and Authority: _____