

## CONTACT INFORMATION

Client Contacts						
Name	Relationship to Client*	Emergency Contact?	Telephone Number	Address	Email	Comments

Relationship to Client:

Mother	Father	Sister	Brother	Grandmother
Foster Mother	Foster Father	Daughter	Son	Grandfather
Legal Guardian	Husband	Wife	Stepdaughter	Stepson
Aunt	Stepmother	Stepfather	Uncle	Other - Specify

Outside Provider Type*/Agency	Outside Provider Name/Title	Medical Record #/Case #	Outside Provider Phone/Address	Outside Provider Email Address

Provider Type:

Primary Care Provider	Probation Officer	Home Health Practitioner	Case Manager	Law Enforcement
Regional Center	School	Therapeutic Behavioral Services	DCFS	Conservator
Other Medical Specialist	Other - Specify	Whole Person Care	Magellan ID	

<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.</p>	<p><b>Name:</b> _____ <b>ID#:</b> _____</p> <p><b>Agency:</b> <b>Los Angeles County – Department of Mental Health</b></p> <p><b>Provider #:</b> _____</p>
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