

DISCLOSURE OF PHYSICIAN PROBATION STATUS

The undersigned client will be or is currently receiving mental health services from:

(Name of Physician under Probationary License)

This disclosure informs the undersigned client and/or responsible adult that the physician named above is on probationary status with the Medical Board of California Licensing Board. This disclosure complies with the Patient Right to Know Act of 2019 to provide this information prior to the client's first visit following the probationary order.

Probationary Information:

1. Probation status: _____
2. Length of probation: _____
3. Probation end date: _____
4. Practice restrictions placed by the licensing board:

For more information, contact the Medical Board of California:

Toll free phone number: 1-800-633-2322

Website: <https://www.mbc.ca.gov/>

- Client is willing to accept / continue with services with the Probationary Licensee.
- Client is unwilling to accept / continue with services with the Probationary Licensee.

Signature of Client

Date

Signature of Responsible Adult

Date

Relationship to Client

Signature of Probationary Licensee

Date

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 prior written authorization 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.

Name: _____ DMH ID#: _____

Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health

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