AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION TO LICENSED RESIDENTIAL FACILITIES

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
ENRICHED RESIDENTIAL CARE PROGRAM

CLIENT/INDIVIDUAL IDENTIFICATION

First Name _____ **Last Name** _____

Street Address _____ **City, State, Zip** _____

IBHIS Number _____ **Date of Birth** _____ **Phone Number** ( )_____

DISCLOSING PARTY/RECIPIENT OF PHI

This authorization allows the Los Angeles County Department of Mental Health (LACDMH) to use and/or disclose my Protected Health Information (PHI) to **Licensed Residential Facilities**, including but not limited to Licensed Adult Residential Facilities, Residential Care Facilities for the Elderly and/or Skilled Nursing Facilities, as it relates to my participation in the **Enriched Residential Care Program (ERCP)**.

Redisclosure Notice:
I understand that my PHI 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.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:
Information needed for the ERCP to help me obtain and retain housing at a Licensed Residential Facility or relocate to another Licensed Residential Facility as needed such as information about my personal characteristics, my medical history, my mental or physical condition, my social service information (including Supplemental Security Income [SSI], General Relief [GR], CalFresh, CalWorks, Cash Assistance Program for Immigrants [CAPI], Medi-Cal and other public benefits that I may apply for) and the treatment and services I receive.

Purpose of Disclosure:
My PHI may be used to see if I am eligible for and to connect me to housing at a Licensed Residential Facility, to coordinate my care with the Licensed Residential Facility, to communicate with the Licensed Residential Facility, to provide me with services, to issue payment for services, to complete program improvement/evaluation activities and for other County program activities.

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NOTICE

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 this form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

EXPIRATION DATE

This Authorization is valid until I am no longer living in a Licensed Residential Facility and/or receiving services from the ERCP.

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.

x ______________________________ ______________

Signature of Client/Individual/Legal Representative **Date**

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

____

REVOCATION OF 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: LACDMH - 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will not affect the ability of LACDMH or any health care provider to use or disclose health information for reasons related to the prior reliance on this Authorization or otherwise allowed by law.

REVOCATION OF AUTHORIZATION

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Name of Client

x ______________________________ ______________

Signature of Client/Individual/Legal Representative **Date**

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

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