# AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PARTICIPATION IN CES

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

### CLIENT/INDIVIDUAL IDENTIFICATION

| | |
|---|---|
| **First Name** | **Last Name** |
| **Street Address** | **City, State, Zip** |
| **IBHIS Number** | **Birth Date** / **Phone Number** ( ) |

### DISCLOSING PARTY - RECIPIENT OF PHI

**This authorization allows:** Department of Mental Health (DMH) to use and/or to disclose my PHI, as described below, and to enter it into the Los Angeles Homeless Management Information System (LA HMIS). I understand that the HMIS is a database used by multiple organizations in LA county that serve clients accessing housing and homeless services and that my PHI will be shared with these organizations through this database. I also understand that my PHI may be used to coordinate services with other Coordinated Entry System (CES) partners.

**REDISCLOSURE NOTICE:**

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law, known as HIPAA, and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is entered into HMIS, it may not be possible to retrieve and my PHI may be subject to re-disclosure.

### DESCRIPTION OF PHI & PURPOSE

**Description of PHI to be Disclosed:**

Information contained in the CES triage and assessment tool such as my name, date of birth, social security number, history of housing and homelessness, self-reported health and emergency services, financial information, citizenship/legal residency status, contact information, whether or not I am receiving services from LACDMH and any additional information that would assist me in attaining housing.

**Purpose of Disclosure:**

My PHI may be used for determination of eligibility for and access to permanent housing resources and for case conferencing to coordinate services with CES partners. This information will also be used to track client information.

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Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

### N O T I C E

**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.

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

*LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.*

### EXPIRATION DATE

**Expiration Date:** This authorization remains valid for seven (7) years or until the participant has secured permanent housing.

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/Individual/Personal Representative** **Date**

If signed by other than client, state relationship and authority to do so: _____

**REVOCATION OF AUTHORIZATION:** I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Housing and Job Development Federal Housing Subsidies Unit, 510 S. Vermont Ave., 17th Floor, Los Angeles, CA 90020. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

### REVOCATION OF AUTHORIZATION

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

If signed by other than client, state relationship and authority to do so: _____