

**AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)**

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

CLIENT:

Name of Client/Previous Names

Birth Date

MIS Number

Street Address

City, State, Zip

AUTHORIZES:

**DISCLOSURE OF PROTECTED HEALTH
INFORMATION TO:**

Name of Agency

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Assessment/Evaluation

___ Results of Psychological Tests

___ Diagnosis

___ Laboratory Results

___ Medication History/

___ Treatment

___ Entire Record (Justify)

Current Medications

___ Other (Specify): _____

PURPOSE OF DISCLOSURE: (Check applicable categories)

___ Client's Request

___ Other (Specify): _____

Will the agency receive any benefits for the disclosure of this information? ___ Yes ___ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

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

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a 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.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

Contact person

Agency Name

Street Address

City, State, Zip

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

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH 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 / Personal Representative

Date

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

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

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

DATE: ____/____/____
Month Day Year