LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT:

Name of Client/Previous Name | Birth Date | Client Number

Name of Legal Representative (If applicable)

Street Address | City, State, ZIP Code

AUTHORIZES:

Name of Agency

Street Address

City, State ZIP Code

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO:

Name of Health Care Provider/Other

Street Address

City, State ZIP Code

INFORMATION TO BE RELEASED:

☐ Assessment/Evaluation ☐ Psychological Test Results ☐ Diagnosis
☐ Laboratory Results ☐ Medication ☐ Treatment/Progress Notes
☐ Entire Record ☐ Other (Specify): _____

NOTE: Information regarding substance or alcohol use, HIV/AIDS, and/or information regarding reproductive or sexual health will NOT be disclosed unless specifically requested by checking the box(es) here: ☐ Alcohol Use ☐ Substance Use ☐ HIV/AIDS ☐ Abortion ☐ Reproductive Health Care

TREATMENT DATES

I authorize records for the following period to be released: From_____ To _____
mm/dd/yyyy mm/dd/yyyy

Method of delivery of requested records:
☐ Mail ☐ Pickup ☐ Email to: _____

PURPOSE OF USE OR DISCLOSURE: (Check applicable category)

☐ Client Request ☐ Other (Specify): _____

I understand that any disclosure of my PHI carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. However, I understand that under California law, the recipient of the PHI under this authorization is prohibited from re-disclosing the PHI, except with a written authorization or as specifically required or permitted by law. I also understand that once my information is used or disclosed, it may not be possible to recall.

EXPIRATION DATE:

Unless otherwise revoked by the patient, this authorization for the release of health care information to the above-named individual/organization will **automatically expire 1 year** from the date of signature, or on the date or event specified below, whichever occurs first.

This Authorization is valid until _____/ _____/ _____ or _____
Month Day Year Event

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of 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 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:

Contact Person	Agency Name
Address	City, State ZIP Code

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

Conditions: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, LACDMH 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/Legal Representative	Date

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

✘

REVOCATION OF AUTHORIZATION

Name of Client

Signature of Client/Legal Representative	Date

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

Printed Name: _____

Relationship and Authority: _____