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

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

CLIENT:

Julia Client	04/25/1971	0123456
Name of Client/Previous Names	Birth Date	MIS Number
123 Example Street, #2,	Los Angeles, CA 90005	
Street Address	City, State, Zip	

AUTHORIZES:

West Central Family MHC
Name of Agency

3751 Stocker Street
Street Address

Los Angeles, CA 90008
City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

MHSA Housing Program
Name of Health Care Provider/Plan/Other

695 S. Vermont Avenue, Suite 1020
Street Address

Los Angeles, CA 90005
City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Assessment/Evaluation
___ Laboratory Results
___ Entire Record (Justify)
___ Results of Psychological Tests
___ Medication History/ Current Medications
___ Diagnosis
___ Treatment
X Other (Specify): The fact that you are receiving mental health services.

PURPOSE OF DISCLOSURE: (Check applicable categories)

X Client's Request
___ Other (Specify):

Will the agency receive any benefits for the disclosure of this information? ___ Yes X 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: 01 / 26 / 2011
Month Day Year

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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

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:

Person submitting form	West Central Family MHC
Contact person	Agency Name
3751 Stocker Street	Los Angeles, CA 90008
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.

Julia Client _____ 1/26/2010

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