

# 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:**

LACDMH

Name of Agency

Name of Health Care Provider/Plan/Other

550 S. Vermont Ave.

Street Address

Street Address

Los Angeles, CA 90020

City, State, Zip Code

City, State, Zip Code

**INFORMATION TO BE RELEASED**

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Results of Psychological Tests | <input type="checkbox"/> Diagnosis            |
| <input type="checkbox"/> Laboratory Results               | <input type="checkbox"/> Medication History/            | <input checked="" type="checkbox"/> Treatment |
| <input type="checkbox"/> Entire Record (Justify)          | <input type="checkbox"/> Current Medications            |   |

Other (Specify): Demographics, social security number, history of housing and homelessness, contact information and any additional information that would assist the individual to obtain housing

**PURPOSE OF DISCLOSURE:** (Check applicable categories)

- Client's Request
- Other (Specify):

PHI will be used to assist with obtaining Permanent Supportive Housing and to coordinate supportive services.

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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OF PROTECTED HEALTH INFORMATION (PHI)**

**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