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

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**
IS / IBHIS Number	**Birth Date**
	( ) Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below by entering information into the Community Solutions, Inc. Performance Management and Communications Platform (PMCP). The PMCP is a database shared by multiple organizations in Los Angeles County such as homeless service agencies, Permanent Supportive Housing providers, the Housing Authorities, emergency shelters, and supportive service providers to assist me with my housing and supportive service needs.

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) and the Match Initiation Form such as demographics, social security number, history of housing and homelessness, self-reported health and emergency services, financial information, citizenship/legal residency status, contact information and any additional information that would assist an individual/family to obtain housing through the Coordinated Entry System.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for permanent housing resources and supportive services. This information will also be used to coordinate services and 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 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 Countywide Housing, Employment, and Education Resource Development Federal Housing Subsidies Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. 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: