

**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:**

- |  |   |                                    |
|--|---|------------------------------------|
| <input 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 type="checkbox"/> Treatment |
| <input type="checkbox"/> Entire Record (Justify) | <input type="checkbox"/> Current Medications            |                                    |
| <input type="checkbox"/> 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: \_\_\_\_\_

<b>REVOCATION OF AUTHORIZATION</b>	
<b>SIGNATURE OF CLIENT/LEGAL REP.</b>	
If signed by other than client, state relationship and authority to do so: _____	
<b>DATE:</b> _____	
Month Day Year	