____
____
____
____

COUNTY OF LOS ANGLES
DEPARTMENT OF PUBLIC SOCIAL SERVICES
Date: ______________________________
Case Name: ______________________________
Case Number: ______________________________
Worker Name: ______________________________
Worker ID: ______________________________
Worker Phone Number: ______________________________
Customer ID: ______________________________

Authorization For Use And Disclosure of Protected Health Information

PURPOSE OF THIS FORM: This form asks you to agree to allow the Department of Public Social Services (DPSS) to get information about your health. DPSS will use this information to determine your benefits.

If you complete and sign this form:

- You agree that your doctor or healthcare provider can share information about your health with DPSS.
- DPSS may share your information.
- You have the right to change your mind at any time.

If you decide not to sign this form:

- This will not affect your healthcare treatment.
- This may affect your DPSS benefits.

____
LAST NAME FIRST NAME DATE OF BIRTH (MM/DD/YYYY)

I authorize (please check all that apply):

- ☐ Antelope Valley Community Clinic
- ☐ CHC/Health Center: ______________________________
- ☐ Community Health Alliance of Pasadena
- ☐ High Desert Multi-Service Ambulatory Care Center
- ☐ Korean Health Education & Research Center
- ☐ Los Angeles Christian Health Center
- ☐ Mission City Community Network
- ☐ Rancho Los Amigos National Rehabilitation Center
- ☐ Central Neighborhood Health Center
- ☐ Harbor-UCLA Medical Center
- ☐ JWCH, Inc.
- ☐ LAC+USC Medical Center
- ☐ Martin Luther King, Jr. Multi-Service Ambulatory Care Center
- ☐ Olive View-UCLA Medical Center
- ☐ St. John's Well Child & Family Clinic

☐ Other: ____
FACILITY NAME STREET ADDRESS CITY STATE ZIP CODE

To release information about my health to:

____
DEPARTMENT OF PUBLIC SOCIAL SERVICES DISTRICT (DPSS) OFFICE NAME

____
STREET ADDRESS CITY STATE ZIP CODE

This authorization is valid until: _____/_____/_____.
END DATE (MM/DD/YYYY)

Information that can be released (please check all that apply):

□ Discharge Summary.
□ History and Physical.
□ Consultation.
□ Operative Report.
□ Radiology Report.
□ Radiology Films.
□ Laboratory / Diagnostic Tests.
□ Medical Progress Notes.
□ Other (Please Specify): ____
____

□ Mental Illness or Mental Health Assessment.
□ Drug and/or Alcohol Abuse Treatment.
□ Symptomatic HIV/AIDS.
□ Sexually Transmitted Disease(s).
□ EKG Report.
□ EEG Report.
□ Summary of Medical History / Treatment.

You have the right to a copy of this form. If you sign this form, you will get a signed copy of the form.

If you refuse to sign this form:

- It will not affect treatment by your health care provider.
- It may impact if you are eligible for DPSS benefits.

_____ I understand and agree that my health care provider may provide information about my health to DPSS. DPSS will use this information to determine my eligibility for benefits.

_____ I understand that DPSS may share information used or released because I signed this form. If this happens, my information is no longer protected by the federal health information privacy law.

I have had the chance to review and understand this form. By signing here, I confirm that this truly reflects my wishes.

____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE PRINT NAME DATE (MM/DD/YYYY)

____
SIGNATURE OF WITNESS PRINT NAME/ RELATIONSHIP TO PATIENT DATE (MM/DD/YYYY)

IF YOU CHANGE YOUR MIND

You have the right to change your mind at any time. After you complete and sign this form, if you change your mind, you must let DPSS know in writing. You may do this by:

- Signing the Revocation of Authorization.
- Mailing or delivering this signed form to the following address:

REVOCATION OF AUTHORIZATION

I hereby revoke the authorization I gave before. I understand that DPSS can use and share health information that my health care provider has already shared with DPSS.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE	PRINT NAME	DATE (MM/DD/YYYY)