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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:

____

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):

- ☐ Mental Condition, including:
  - Your mental health conditions.
  - The onset date of any mental condition.
  - Whether you are actively being treated for your condition.
  - How long your condition is expected to last.
  - Whether your condition affects if you can work or be in a work-training program.
- ☐ Other (Please Specify) ________________________________

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)