COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

LAST NAME FIRST NAME DATE OF BIRTH (MO/DY/YR)

HEREBY AUTHORIZES

_____

FACILITY NAME STREET ADDRESS CITY STATE ZIP CODE

To Release Protected Health Information To:

_____

DEPARTMENT OF PUBLIC SOCIAL SERVICES DISTRICT (DPSS) OFFICE NAME

_____

STREET ADDRESS CITY STATE ZIP CODE

EXPIRATION DATE: This Authorization is valid until the following date: _____/_____/20____

INFORMATION TO BE DISCLOSED

□ Mental Condition □ Other (Please Specify) _____

_____I understand and agree that my health care provider may fill out and provide to DPSS the ABP 1676-3 GRMH form for DPSS to determine my eligibility for benefits; this includes providing DPSS information concerning any mental health impairment, the onset date of my condition, whether I am actively seeking treatment, the expected duration of my condition; whether this would affect my ability to participate in a work or work-related training program. I understand that the health information used or disclosed as a result of my signing this Authorization form may be subject to redisclosure and no longer protected by federal health information privacy law.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization – I understand that if I sign this Authorization, I will 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 from my health care provider, but doing so may impact my eligibility to receive DPSS benefits.

I have had the 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 PATIENT/LEGAL REPRESENTATIVE PRINT NAME DATE

_____

SIGNATURE OF WITNESS PRINT NAME/ RELATIONSHIP TO PATIENT DATE

Right to Revoke This Authorization – I understand that I have the right to revoke this Authorization at any time by telling DPSS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following address:

I also understand that a revocation will not affect the ability of DPSS or any health care provider to use or disclose the health information or reasons related to the prior reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Patient/Legal Representative: **Date:**

_____

If signed by other than patient, state relationship and authority to do so