DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name First MI | Date of Birth (Mo/D/Yr) | Medical Record Number

HEREBY AUTHORIZES:

- ☐ LAC+USC Medical Center
- ☐ Harbor-UCLA Medical Center:
- ☐ King Drew Medical Center
- ☐ Olive View Medical Center
- ☐ High Desert Hospital
- ☐ CHC/Health Center: _____

To Release Protected Health Information To:

Name of Facility/Health Care Provider/Plan/Other

Street Address

City State Zip Code

for the time period beginning _____ (DATE), and ending _____ (DATE)

INFORMATION TO BE DISCLOSED

PLEA SE CHECK ALL APPROPRIATE BOXES:

- ☐ Summary Of Medical History / Treatment
- ☐ Laboratory Diagnostic Tests
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Psychological Testing
- ☐ HIV/AIDS
- ☐ Sexually Transmitted Disease(s)
- ☐ Mental Illness Or Mental Health Assessment
- ☐ Drug and/or Alcohol Abuse Treatment
- ☐ Other (Please Specify)
- ☐ History and Physical
- ☐ Medical Progress Notes
- ☐ Radiology Records
- ☐ Radiology Films
- ☐ EKG Report
- ☐ EEG Report
- ☐ Operative Report

THE PURPOSE OF THE DISCLOSURE - PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date, _____ / _____ / _____

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 DHS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to:

_____
_____
_____
_____

I also understand that a revocation will not affect the ability of DHS 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, DHS 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 Patient/Legal Representative: _____

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

_____

DATE:_____ /_____ /_____ **WITNESS:** _____
Month Day Year

REVOCATION OF AUTHORIZATION

Signature Of Patient/Legal Representative:

_____

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

_____

DATE: _____ /_____ /_____
Month Day Year