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

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

To Release Protected Health Information To:

Department of Public Social Services District Office Name Street Address

City State Zip Code

For the time period beginning, _____ (Date), and ending _____ (Date).

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

INFORMATION TO BE DISCLOSED

PLEASE CHECK ALL APPROPRIATE BOXES:

□ 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

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

_____ I understand and agree to have my health care provider complete and return ABP 1676-1 form to Department of Public Social Services (DPSS) so they can determine my eligibility to receive benefits.

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.

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 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 Print Name Date

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

_____ Date: _____/_____/_____

Witness: _____ Print Name _____

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:

_____