DEPARTMENT OF HEALTH SERVICES – COUNTY OF LOS ANGELES
JUVENILE COURT HEALTH SERVICES

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name _____ First Name _____ MI _____ Date of Birth (Mo/D/Yr) _____ PDJ# _____

HEREBY AUTHORIZES

☐ BARRY J. NIDORF JUVENILE HALL	16350 Filbert Street, Sylmar, CA 91342
☐ CENTRAL JUVENILE HALL	1605 Eastlake Ave., Los Angeles, CA 90033
☐ LOS PADRINOS JUVENILE HALL	7285 Quill Drive, Downey, CA 90242
☐ CMYC- CAMPS – CHALLENGER	5300 West Avenue I, Lancaster CA 93536

☐ OTHER:

To Release Protected Health Information To:

Name of Facility/Health Care Provider/Plan _____ Telephone Number _____

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: _____ (Month) / _____ (Day) /20___ (Year)

INFORMATION TO BE DISCLOSED

PLEASE CHECK ALL APPROPRIATE BOXES:

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

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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.

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. 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 **Print Name**

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

_____ Date:_____/_____/ 20___

Witness:_____ Print Name:_____

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 the following facility address:

Medical Records Director
Juvenile Court Health Services
1925 Daly Street
Los Angeles, CA 90031

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.

REVOCATION OF AUTHORIZATION

DEPARTMENT OF HEALTH SERVICES – COUNTY OF LOS ANGELES

Signature of Patient/Legal Representative:_____

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

_____ Date: _____/_____/ 20___