

**DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES**

Page 2 -AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

REVOCAION 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