**** JUVENILE COURT HEALTH SERVICES MEDICAL RECORDS / HIM SERVICES

 **CENTRAL JUVENILE HALL**

 1605 Eastlake Ave. Los Angeles, CA 90033

 Tel: 323-226-8852 Fax: 323-221-9222

**AUTHORIZATION FOR USE AND DISCLOSURE**

**OF**

**PROTECTED HEALTH INFORMATION**

Last name First MI Date of Birth PDJ #

Authorization:

I hereby authorize:

 Name of Facility / Health Care Provider/ Plan / Other

 Address City State Zip Code

To release Protected Health Information to: JCHS-Medical Records / HIM Health Services

 1605 Eastlake Ave Los Angeles CA 90033

 Address City State Zip code

Medical records and information pertaining to Medical History, Physical condition, services rendered and treatment for continuous health care.

For the time period beginning and ending

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:

 Date

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, JCHS 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 / Parent / Guardian Relationship to Patient 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 JCHS in writing. I may use the Revocation of Authorization at the bottom of this form.

Mail or deliver the revocation to:

**JUVENILE COURT HEALTH SERVICES**

**HIM/MEDICAL RECORDS**

**1925 DALY ST. 1ST FLOOR**

**LOS ANGELES, CA 90031**

I also understand that a revocation will not affect the ability of JCHS 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**

 Signature of Patient / Parent / Guardian Relationship to Patient Date