

Appendix 6

MENTAL HEALTH ADVOCACY SERVICES, INC.

A NONPROFIT ORGANIZATION PROVIDING LEGAL SERVICES TO PEOPLE WITH MENTAL AND DEVELOPMENTAL DISABILITIES

3255 WILSHIRE BLVD., SUITE 902
LOS ANGELES, CA 90010

PHONE (213) 389-2077
FAX (213) 389-2595

COMBINED AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND OTHER RECORDS

- *(This authorization complies with applicable federal and state laws, including HIPPA and CIMA)¹*
- *(This authorization does not include psychotherapy notes, which are requested under a separate authorization; see 45 C.F.R. §164.508(b)(3))*

I, ___ **[client name]** ___, voluntarily request and authorize disclosure (including paper, oral, and electronic transmission) of my protected health information, including medical and mental health records, including information created within 12 months after the date on which this authorization is signed by me, as well as past information.

This authorization includes, but is not limited to, specific permission to release all of the following protected health information pertaining to me:

- All records related to diagnosis and / or treatment of mental or developmental conditions and / or disabilities, and / or any other mental or developmental impairments, including, but not limited to, mental health assessments, screenings, progress reports, treatment summaries, results of tests administered to determine the presence of a mental and / or developmental disabilities (but not including psychotherapy notes);
- All records related to diagnosis and / or treatment of drug abuse and / or addiction, alcohol abuse and / or addiction, or any other substance or chemical abuse and / or addiction;
- Any and all additional records pertaining to me, including ___ **all legal records** ___.

¹ *This authorization complies with the Health Insurance Portability and Accountability Act ("HIPPA"), as amended, and with all implementing regulations, including the 'Privacy Rule;' see Public Law 104-191 and implementing regulations, including 45 C.F.R. § 164.508; complies with California's Confidentiality of Medical Information Act ("CIMA") (see Cal. Civ. Code §56- §56.37).*

I hereby authorize _____ [**name of institution releasing records**] _____ to make disclosure of all protected health information requested herein that is in its possession, including all records obtained from other sources.

This information is to be disclosed to **Mental Health Advocacy Services, Inc.** (“MHAS”), including its attorneys and representatives, for the purpose of providing me with legal representation.

I understand the following regarding this authorization:

- This information will not be released to any other person, agency, or entity without my consent;
- A photocopy of this authorization has the same effect as the original;
- This authorization is valid for 12 months from the date on which I sign it, after which point it expires;
- Except for action already taken in reliance on this authorization, I may revoke this authorization at any time under the Federal Privacy Rule;
- I am entitled to a copy of this signed authorization upon my request.

Printed Name of Client: _____

Date of Birth of Client: _____

Signature of Client: _____

Date of Client Signature: _____

MHAS (name and title): _____ **Greg Pleasants, Esq., Staff Attorney, Mental Health Advocacy Services** _____