

**LA Permanent Supportive Housing Initiative
CoC Program Rental Assistance
AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize release of personal identified information, regarding the person named below, within the following specified limits:

1) Name:

_____ SSN: _____ DOB: _____

2) Specific information to be released are: (1) the access and use of electronic records on supportive services utilization and costs from Federal and State Programs administered by the LA Department of Health and Hospitals and LA Department of Children and Family Services to the LA Housing Corporation; and (2) individual and income information required for the administration and provision of a CoC Program rental subsidy to the LA Housing Corporation.

3) Other information to be released: _____

4) The purpose for which the information is to be released is to support (1) the provision of a CoC Program rental subsidy thereby accomplishing all CoC Program requirements and (2) the provision of support services.

Other purposes

include: _____

5) Organization/Address/Person to which this information is to be released:

6) Organization/Address/Person releasing the information:

7) I wish to review this information before it is released: *(Initial one of these)*

Yes _____ No _____

8) The benefits, risks, and consequences of the alternatives in releasing or not releasing this information have been explained to me: *(Initial one of these)*

Yes _____ No _____

9) If this released information contains any reference to any of the following, the release of that information is/is not authorized by my initials:

HIV Yes _____ AIDS Yes _____ STDs Yes _____ TB Yes _____
No _____ No _____ No _____ No _____

10) **Unless otherwise specified below, this authorization will expire in fifteen (15) months.**

Date this authorization will expire:

11) I understand that I may revoke this authorization in writing at any time.

*****This information may not be further disclosed by the receiving person or organization without my authorization.*****

Authorization for Release of Above Information: (In order to be valid, this authorization must have the proper accompanying advisories and State and Federal citations on the reverse side of this page.)

Printed Name Of Person Authorizing Release

Relationship

Signature/Mark of Person Authorizing Release

Date

Witness (if Mark/Stamp): Printed Name
Signature

Witness

Revocation of Release:

Signature (or mark & signature of witnessing person)

Date

Advisories:

- You may refuse to sign the authorization to disclose some or all of your health care information, but you should be aware that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other insurance or other adverse consequences.
- You may revoke this authorization at any time by a written revocation and by delivering it to the person or organization holding the release of information authorization. However, this revocation is subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation.
- You are entitled to a copy of this authorization form.

For Persons/Organizations Receiving Substance Abuse Information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)