



Authorization to Release Information

Main Hospital

1891 Effie Street
Los Angeles, CA 90026
P: 323.644.2000
F: 323.544.6391

CONREP / FCTP LA

621 S. Virgil Avenue
Los Angeles, CA 90005
P: 213.368.5400
F: 213.368.5454

**Child & Adolescent
Outpatient Program**

711 W College St, Ste 500
Los Angeles, CA 90012
P: 323.644.2000
F: 323.644.2793

Homeless Services

320 N. Madison Avenue
Los Angeles, CA 90004
P: 323.644.2026
F: 213.342.3118

Normandie Village East

1355 S. Hill Street
Los Angeles, CA 90015
P: 213.389.5820
F: 213.402.3136

Percy Village

3455 Percy Street
Los Angeles, CA 90023
P: 323.268.2100
F: 323.983.7530

Wellness Services

433 N. Hoover Street
Los Angeles, CA 90004
P: 323.644.2040 | F:
213.342.3118

Satellite / STRP

437 N. Hoover
Los Angeles, CA 90026
P: 323.644.2030
F: 323.660.6866

CONREP / FCTP SD

450 A Street, Fifth Floor
San Diego, CA 92101
P: 619.544.1435
F: 619.393.0715

**Crisis Residential / Social
Rehabilitation Treatment
Program**

423 N Hoover
Los Angeles, CA 90004
P: 323.300.1830
F: 323.544.6555

**Addiction Healing and
Recovery Program**

1891 Effie Street
Los Angeles, CA 90026
P: 323.644.2000
F: 323.544.6391

**Enhanced Care
Management**

711 W. College St
Los Angeles, CA 90012
P: 323.644.2000
F: 323.544.6391

This authorization to receive or release medical information is being requested of you in order to comply with the terms of the Confidentiality of Medical Information Act of 1980, section et seq. of the California Civil Code and Section 5328 et. Seq. of the Welfare & Institutions Code.

Patient Information:

Patient Name: _____

Birthdate: _____

Admission and/or Treatment Date(s): _____

Phone Number: _____

Email: _____

Address: _____

Authorization/Purpose:

I hereby authorize GATEWAYS HOSPITAL & MENTAL HEALTH CENTER (Physician, Hospital, Health Care Provider, or Individual) to receive or release the indicated information pertaining to services and treatment rendered for the following use/reason:

Name of Requester/Recipient: _____

Address: _____

Phone Number: _____ Fax Number: _____



Authorization to Release Information

Email address: _____

Information to be released/received:

Duration: This authorization shall be effective immediately and is subject to revocation by the undersigned at any time to the extent that action has been taken in reliance hereon and if not revoked it shall terminate on _____ (date) or in one year, without express revocation.

Authorization

I have carefully read and understood the foregoing. I consent to the release of the above specified information about, or medical records of, my condition and the treatment/service I have received in the course of my diagnosis and treatment which may include psychiatric illness, STD, HIV alcohol/drug use, reproductive health care, and/or abortion to those persons or agencies listed.

I further understand that the information released may contain potentially harmful information and release my treatment team, their associates, Gateways Hospital and Mental Health Center and its employees and agents from any liability arising from the release of this information or records designated persons and agencies.

Restriction: Release or transfer of unspecified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity. The information provided may be used only for the purposes noted.

The undersigned hereby authorizes the release of information to the party specified above. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization

NOTE: A COPY OF PHOTO ID MUST BE INCLUDED WITH AUTHORIZATION

_____ Name of Authorized Representative	_____ Signature	_____ Date
<i>Relationship to patient if signed by someone other than the patient:</i>		

_____ Name of Witness	_____ Signature	_____ Date
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REVOCATION OF AUTHORIZATION

Gateways Hospital & Mental Health Center shall be held harmless for any records released prior to receiving revocation notice.

Patient and/or Authorized Representative revokes this authorization as of _____ (date).

_____ Staff Name	_____ Staff Signature	_____ Date
_____ Patient/Authorized Representative Name	_____ Patient/Authorized Representative Signature	_____ Date