Life Skills Center

1111 Figueroa Place T-215, Wilmington, CA 90744 (310) 233-4586

CONSENT FOR RELEASE/RECEIPT OF CONFIDENTIAL HEALTH INFORMATION

_____ Student ID# _____

I (print name

Authorize Los Angeles Harbor College Life Skills Center to:

RELEASE Confidential information pertaining to

me. TO (Receiving agency/Person): _____

Name _____ _____

Phone ( ) FAX ( ) _____

Address _____

City & State

The disclosure shall be limited to the following specific information (*Nature and amount of information to be disclosed; as limited as possible to accomplish the stated purpose or intended use):*

___ Summary of psychological and psychiatric history ___ Diagnosis

___ Result of psychological and vocational tests _ Other: _____

I understand that: 1) My mental health records are protected under the California Welfare and Institutions Code (WIC) and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The exceptions are set forth in the Notice of Privacy Practices; 2) I may revoke this consent at any time by informing the above parties in writing. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

I have read this authorization for release of information and fully understand its contents and my rights pursuant to HIPAA

_____ _____

Life Skills Center Client Signature Date