



County of San Bernardino  
Department of Behavioral Health

PATIENTS' RIGHTS GRIEVANCE FORM

For Office Use Only:  
Simon # \_\_\_\_\_

FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO PATIENTS' RIGHTS

850 East Foothill Boulevard, Rialto, CA 92376  
(800) 440-2391 ♦ Fax (909) 421-9258

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
(Please print or write clearly)

Using Authorized Representative:  No  Yes if yes, Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  M  F Preferred Language: \_\_\_\_\_

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic or Provider: \_\_\_\_\_

Please Tell Us About Your Grievance: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How Would You Like to See Things Resolved? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Beneficiary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

County of San Bernardino Department of Behavioral Health  
**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Name of Client: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____ Social Security: _____
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Completion of this document authorizes the release, disclosure, and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize \_\_\_\_\_ to release to:  
(Facility Name/Provider/Other)

Patients' Rights, 850 East Foothill Boulevard, Rialto, CA 92376, (800) 440-2391, Fax (909) 421-9258

- a.  All health information pertaining to my medical history, mental or physical condition and treatment received – **OR**  
 Only the following records or types of health information (including any dates):  
\_\_\_\_\_

- b. I specifically authorize release of the following information (check as appropriate):
- Mental health treatment information
  - HIV test results
  - Alcohol/drug treatment information

**PURPOSE**

Purpose of requested use or disclosure:

Information requested is required in order to (1) assist in achieving a resolution of my grievance, and (2) help the Quality Improvement Program of DBH prevent similar problems from occurring in the future.

**To Agencies Receiving This Information:** This information is protected by state and federal laws and should not be given to anyone else not included on this Authorization without a new Authorization from the client, unless otherwise authorized by law. If you have received alcohol and/or drug assessment, treatment, or referral program information, the following applies: **This information has been disclosed to you from records protected by Federal confidentiality law/rule (42 CFR, Part 2). The Federal rules forbid you from making another/any further release/disclosure of this information unless expressly/specifically permitted by the written consent of the person signing this Authorization or as allowed by Federal law/rule (42 CFR, Part 2). A general Authorization of medical or other information is NOT sufficient for this purpose. The Federal laws/rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

**EXPIRATION**

This Authorization expires [insert date]: \_\_\_\_\_

(please see other side)

County of San Bernardino Department of Behavioral Health  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**MY RIGHTS**

- I may refuse to sign this Authorization. It will not affect my ability to get treatment.
- I have a right to receive a copy of this Authorization.
- To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but must do so in writing and submit it to the following address: \_\_\_\_\_

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Information released by this Authorization could be re-released by whoever receives it, and the re-release is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

**SIGNATURE**

Date: \_\_\_\_\_

Time: \_\_\_\_\_  am  pm

Signature: \_\_\_\_\_  
*(patient/representative/spouse/financially responsible party)*

If signed by someone other than the patient, state your legal relationship to the patient:

Witness: \_\_\_\_\_