



**County of San Bernardino
Department of Behavioral Health
PATIENTS' RIGHTS OFFICE GRIEVANCE APPEAL FORM**

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

850 East Foothill Blvd., Rialto, CA 92375
Office (909) 421-4657 ♦ Toll Free (800) 440-2391 ♦ Fax (909) 421-9258

Client Name: _____ **Date:** _____

Date of Birth: _____ **Gender:** M F **Preferred Language:** _____

Home Address: _____

City: _____ **Zip:** _____ **Phone:** _____

Alternate Phone: _____

Facility or Provider Name: _____

Using Authorized Representative: No Yes if yes,

Name: _____

Phone: _____

What is your complaint regarding the way in which your original grievance was resolved?

Once you have completed this Appeal form, an Advocate from Patients' Rights will contact you to discuss your appeal. In order to help resolve your appeal, Patients' Rights may need to discuss your concerns with other individuals. These other individuals might include your service provider, your provider's supervisor, or administrators within the Department of Behavioral Health. In order to allow Patients' Rights to discuss your appeal with these other individuals, we need to obtain your written permission to release information about your appeal.



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 Blvd., Rialto, CA 92375, (909) 421-4657, Toll Free (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: patient request; **OR** other:

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: Patients' Rights, 850 East Foothill Blvd., Rialto, CA 92375

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: _____
