



**County of San Bernardino  
Department of Behavioral Health**

**GRIEVANCE FORM**

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

**FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO THE ACCESS UNIT**

268 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415-0026  
909-381-2420 ♦ 888-743-1478 ♦ TDD 888-743-1481 ♦ Fax 909-421-9272

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

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

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

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

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

**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: \_\_\_\_\_