

**AUTHORITY TO RELEASE SUBSTANCE ABUSE PATIENT RECORDS
OF**

(Name)

(Social Security #)

(Birthdate)

Date:

Send Records To:

To:

**THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
360 E. Second Street, Ste. 400
Los Angeles, CA 90012**

I, _____, hereby authorize _____
(Name) (Name of Organization)

This will be your authority to release information and records pertaining to the treatment and/or hospitalization of the above named individual for substance abuse or chemical dependency to the City of Los Angeles Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners.

Disclosure of requested records shall be limited to the following specific types of information: admission summaries; history and physical examination reports; laboratory data including blood chemistries and urinalyses; treatment reports; pharmacy and prescription orders; physicians', therapists', and nurses' notes/orders; and discharge summaries.

The purpose of this request for records is to assist the Department of Fire and Police Pensions in the processing or review of an application for disability pension benefits. This authorization shall be considered valid for five (5) years from the date signed.

I certify that I have read, understand, and agree with the above provisions of this consent.

(Date)

(Signature)

Your prompt attention to this matter will be appreciated. If you have any questions, feel free to call Pension Claims Analyst _____ at the Department of Fire and Police Pensions, Disability Section: (213) 978-4500.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].