California Problem Gambling Treatment Services Program
Consent to Release Confidential Information

I_____ authorize _____
(Client name) (Provider name)

to disclose to the Office of Problem Gambling and its designee, the UCLA Gambling Studies Program, information regarding my enrollment and services provided in the California Problem Gambling Treatment Services Program (CPGTSP).

The purpose of the disclosure authorized herein is to verify my eligibility and participation in the CPGTSP and to allow the State to reimburse my provider for treatment services provided.

I understand that my records are protected under the federal Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulation at 45CFR, Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent automatically expires one year after I discontinue all CPGTSP services.

I have been provided a copy of this form.

□ **I consent to release confidential information to the Office of Problem Gambling and its designee.**

Client Signature: _____ Date: _____

_____ Date: _____
Parent, guardian or authorized representative signature (if required)

Program/Provider Name: _____

CPGTSP Provider # _____