UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Patient Information	_____ _____ Patient Name Medical Record # Street Address: _____ City, State & Zip Code: _____ Date of Birth (MMDDYYYY): _____Phone: (____) _____ E-Mail Address: _____
Specify Healthcare Facility	☐ UCLA Health Hospitals/Clinics Doctor/Clinic _____ ☐ Jules Stein Eye Institute ☐ Resnick Neuropsychiatric Hospital
Release Records to *Where do you want records sent?*	I authorize **UCLA Health** to release PHI to: Name of Hospital/Clinic/Person: _____ Street Address: _____ City, State & Zip Code: _____ Phone: (____) _____ FAX: (____) _____ *E-Mail Address: _____ *Note: Provide your email address to receive an email status of your request.
Delivery Instructions *(please select one)*	☐ CD ☐ E-Mail ☐ Paper Copy (Neuropsychiatric Hospital/Behavioral Health Sciences does not release via email) **Note:** If left blank, a CD will be provided. *See page 2 for myUCLAhealth information
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☐ Other (state reason) _____
Health Information to be Released: *What records are being requested?*	**Type of Records:** ☐ Clinic Visit (office notes & consultations) ☐ Billing Statements ☐ Emergency Reports (ER) ☐ Pathology Reports ☐ Consultations ☐ History & Physical Exams ☐ Progress Notes ☐ Discharge Summary ☐ Jules Stein Images ☐ Radiology Images (x-rays) ☐ EEG Video ☐ Laboratory Reports ☐ EKG ☐ Operative Reports ☐ Radiology Reports ☐ Other: ☐ Mental Health (Neuropsychiatric Hospital & Clinic Records)

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results
Specify Date/Time Period	ESTIMATE/SPECIFY DATE RANGE FOR RECORDS BEING REQUESTED: FROM MM / DD / YYYY TO MM / DD / YYYY
Expiration of Authorization	Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated this Authorization will expire 12 months after the date signed.
Signature(s)	_____ _____ (Signature of Patient / Legal Representative) Date _____ _____ Printed Name Area Code/Phone Number If signed by someone other than the patient, indicate relationship to the patient _____ _____ _____ Signature of Witness (only if patient unable to sign) or Interpreter Date Interpreter ID #_____

Mailing Addresses	
UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-902 Los Angeles, CA 90095-1776 Fax: (310) 983-1468 | Phone: (310) 825-6021 Email: roi@mednet.ucla.edu	**Image Management, Release of Information** 200 Medical Plaza B1- Level | Suite 165-11 Los Angeles CA 90095 Fax 310-825-3205 | Phone 310-825-6425
Mental Health Records RNPH/BHS HIMS 10833 Le Conte Ave BH239A Los Angeles CA 90095 Fax 310-206-7682 Phone 310-267-2661 or 310-794-1530 Email: NPHROI@mednet.ucla.edu	**Request medical records via myUCLAhealth.** **Visit our website for information: https://www.uclahealth.org/medical-records** **For assistance with your myUCLAhealth account, call: 855-364-7052.**

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To protect our patient's confidential medical information we must have a valid, complete and legible authorization to disclose their health information.

All sections of this authorization must be completely filled out before UCLA Health is permitted to disclose your protected health information.

Notice

UCLA Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Revocation

I may revoke this authorization at any time, provide that I do so in writing and submit it to:

UCLA Health
Health Information Management Services
10833 Le Conte Avenue, CHS BH-902
Los Angeles, CA 90095-7305

The revocation will take effect when UCLA Health receives it, except to the extent that UCLA Health or others have already relied on it.

My Rights

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:

1) conducting research-related treatment,
2) obtaining information in connection with eligibility or enrollment in a health plan,
3) determining an entity's obligation to pay a claim, or
4) creating PHI to provide to a third party.

I am entitled to receive a copy of this Authorization.

Requesting records using the UCLA Health patient portal is available for patients and their proxies. Visit myUCLAhealth at: https://www.uclahealth.org/medical-records

For assistance with your myUCLAhealth account, call: 855-364-7052