

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN: _____
 Patient Name: _____

 (Patient Label)

<p>Patient Information</p>	<p>Patient Name: _____ MRN: _____ Address: _____ City, State & Zip Code: _____ Date of Birth (MMDDYYYY): _____ Phone: (____) _____</p>														
<p>Specify Healthcare Facility</p>	<p><input type="checkbox"/> UCLA Health Hospitals/Clinics <input type="checkbox"/> Jules Stein Eye Institute <input type="checkbox"/> Resnick Neuropsychiatric Hospital</p>														
<p>Release Records to Where do you want records sent? Who do you want to receive records?</p>	<p>I authorize UCLA Health to release PHI to: Name of Hospital/Clinic/Person: _____ Address: _____ City, State & Zip Code: _____ Phone: (____) _____ FAX: (____) _____ E-Mail Address: _____ If you would like a designee* to pick up your records, please fill out section below: I authorize _____ to pick up my medical record copies. Relationship to patient: _____ *Note: Designee must provide valid photo ID</p>														
<p>Delivery Instructions (please select <u>one</u>)</p>	<p><input type="checkbox"/> CD <input type="checkbox"/> E-Mail (NPH/BHS does not release via email) <input type="checkbox"/> Paper Copy <input type="checkbox"/> Call Requestor when records are ready for pick up Note: If left blank, a CD will be provided.</p>														
<p>Purpose What is the purpose of this release?</p>	<p><input type="checkbox"/> At the request of the patient/patient representative <input type="checkbox"/> Other (state reason) _____</p>														
<p>Health Information to be Released: What records are being requested?</p>	<p>Type of Records:</p> <table border="1"> <tr> <td><input type="checkbox"/> Medical Records</td> <td><input type="checkbox"/> Mental Health (other than psychotherapy notes)</td> </tr> <tr> <td><input type="checkbox"/> Billing Statements</td> <td><input type="checkbox"/> Emergency Reports (ER)</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> History & Physical Exams</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Jules Stein Images</td> </tr> <tr> <td><input type="checkbox"/> EEG Video</td> <td><input type="checkbox"/> Laboratory Reports</td> </tr> <tr> <td><input type="checkbox"/> EKG</td> <td><input type="checkbox"/> Operative Reports</td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td></td> </tr> </table>	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Mental Health (other than psychotherapy notes)	<input type="checkbox"/> Billing Statements	<input type="checkbox"/> Emergency Reports (ER)	<input type="checkbox"/> Consultations	<input type="checkbox"/> History & Physical Exams	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Jules Stein Images	<input type="checkbox"/> EEG Video	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> EKG	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Other:	
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Sensitive Information	<p>Sensitive information will not be released unless specifically authorized below:</p> <p><input type="checkbox"/> Drug and Alcohol Abuse Results <input type="checkbox"/> Genetic Testing Information</p> <p><input type="checkbox"/> HIV/AIDS Test Results <input type="checkbox"/> Psychological/Vocational Results</p>
Specify Date/Time Period	<p>SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE:</p> <p>FROM MM / DD / YYYY TO MM / DD / YYYY</p>
Expiration of Authorization	<p>Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event).</p> <p>If no date is indicated this Authorization will expire 12 months after the date signed.</p>
Signature(s)	<p>_____</p> <p>(Signature of Patient / Legal Representative) Date</p> <p>_____</p> <p>Printed Name Area Code/Phone Number</p> <p>If signed by someone other than the patient, indicate relationship to the patient _____</p> <p>_____</p> <p>Signature of Witness (only if patient unable to sign) Date or Interpreter Interpreter ID # _____</p>

Mailing Addresses	
<input type="checkbox"/> Please check box for medical records	<input type="checkbox"/> Please check box for radiology images
<p>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</p>	<p>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</p>
<input type="checkbox"/> Please check box for mental health records	
<p>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</p>	
Release of Information Customer Service – Walk-in Service	
<p>Open Hours 8a-4:30pm</p> <p>Closed Lunch 11:30a-12:30p</p>	<p>Ronald Reagan UCLA: 100 Med Plaza, Suite 140, Los Angeles, CA 90095 Phone: (310) 825-6021 Fax: (310) 983-1468 Email: roi@mednet.ucla.edu</p> <p>Santa Monica UCLA: 1260 – 15th Street, Suite 802B, Santa Monica, CA 90404 Phone: (424) 259-8045 Fax: (310) 983-1468 Email: roi@mednet.ucla.edu</p>

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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.