The Physicians, Faculty, and Staff of the UCLA Division of Plastic and Reconstructive Surgery are dedicated to protecting your personal information. In accordance with federal regulations, we ask that you bring the following with you to every visit:

1. A copy of your insurance card showing your policy number, group or certificate number.

2. A current government or state issued photo ID (such as a military identification card, a driver's license, passport, border crossing card, etc.), or a school issued photo ID.

3. Your Medicare or Medi-Cal card (if applicable).

4. A complete list of any medications, vitamins, or supplements that you are currently taking.

Please plan to arrive 15 minutes early to insure that you have sufficient time to complete any additional paperwork that your visit may require.

We look forward to providing you with an effortless check-in process.

Thank you,

Carolyn Casillas
Division Administrator
UCLA Division of Plastic and Reconstructive Surgery

Address:

UCLA Division of Plastic & Reconstructive Surgery
200 UCLA Medical Plaza, Suite 465
Los Angeles, CA 90095

Phone: (310) 825-5510
Fax: (310) 206-7579

Driving Directions:

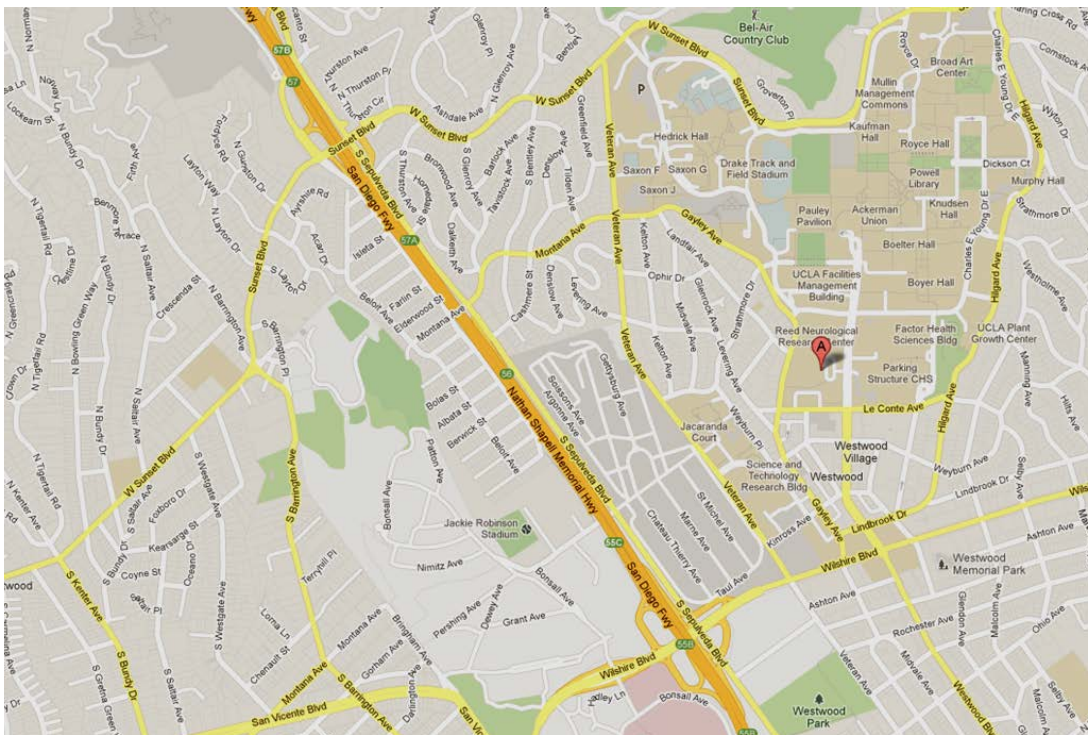
From the north or south via the San Diego Freeway (405):
From the north, exit Wilshire East; or from the south, exit Wilshire Westwood. At the third traffic light, turn left on Westwood Blvd. Proceed across Le Conte Avenue and at the next light, Medical Plaza Drive, turn left and follow the ramp down to the parking lot below. Additional parking can be found north of Le Conte Avenue on Gayley Avenue, two blocks west of Westwood Plaza.

From Los Angeles International Airport (LAX):
Take the San Diego Freeway northbound to Wilshire Boulevard east, and continue as described above.

From the east via the Santa Monica Freeway:
Take the 10 (Santa Monica Freeway) East to the 405 (San Diego Freeway) North, and exit on Wilshire Boulevard east. Continue as described above.

Parking:

Parking is available at the UCLA Medical Plaza at the rate of $12 per day.



Affix Patient Label Here

Name:______________________________ Date of Birth:_______________________________

Height:________ Weight:___________ Left / Right Handed (please circle)

Reason for Consultation:____

Primary Care Physician:

Name:_____________________________________ Phone:_____________________
Address:___________________________________ Fax:________________________
City:_______________________________________
State:______ Zip:_________________________

Referred By:

Name:_____________________________________ Phone:_____________________
Address:___________________________________ Fax:________________________
City:_______________________________________
State:______ Zip:_________________________

Smoking History:

- ❐ Never smoked
- ❐ Currently smoking ______ packs per day
- ❐ Quit less than 2 months ago, previously smoked _____packs per day
- ❐ Quit more than 2 months ago, previously smoked __________ packs per day
- ❐ Current using nicotine replacement therapy (patch, gum, etc.)

Alcohol Use:

- ❐ Yes – amount per week:______________________________
- ❐ No

Living Situation:

- ❐ Alone
- ❐ With adults
- ❐ With dependents

Marital Status:

- ❐ Single
- ❐ Domestic Partnership
- ❐ Married
- ❐ Separated
- ❐ Divorced
- ❐ Widowed

Number of Pregnancies:______________ Number of Children:_________________

Affix Patient Label Here

Current Medications:

❒ No Medications

1. ____________________ Dosage: ______________________
2. ____________________ Dosage: ______________________
3. ____________________ Dosage: ______________________
4. ____________________ Dosage: ______________________

Please continue your list on an additional page, if needed.

Drug Allergies:

❒ No Allergies

1. ____
2. ____
3. ____
4. ____

Please continue your list on an additional page, if needed.

Vision:

Have you ever experienced vision problems?
❒ Yes ❒ No

If Yes, please describe:________________________________

Do you wear glasses or contacts? ❒ Yes ❒ No

Last Eye Exam? ____
By whom? ____

Surgical History:

Procedure:____
Performed by:____
Date:____

Procedure:____
Performed by:____
Date:____

Procedure:____
Performed by:____
Date:____

Have you experienced problems with Anesthesia?
❒ Yes ❒ No

If Yes, please describe:________________________________

Affix Patient Label Here

Physical Exam:

Date of your most recent physical:______________________
Completed by:______________________________________
Date of most recent EKG:___________________________
Date of most recent Stress EKG:______________________
Date of most recent Chest X-Ray:_____________________

Do you sleep well? ❒ Yes ❒ No

Significant Family Medical History:

____
____
____
____

Significant Personal Medical History:

____
____
____
____

Review of Symptoms: (check all that apply)

History of:	Current Symptom:	Condition:	Explanation:
❒	❒	CNS, Stroke, Migraines, Headaches	____________
❒	❒	Psychological, Emotional, or Stress Disorders	____________
❒	❒	Eye, Ear, Nose, Throat, or Sinus Problems	

History of:	Current Symptom:	Condition:	Explanation:
❒	❒	Neck Pain	
❒	❒	Birth Defects: cleft lip, cleft palate, etc.	
❒	❒	Dental or tooth-related problems	
❒	❒	Pulmonary, Emphysema, Airway or Breathing Problems	
❒	❒	Cardiovascular Problems	
❒	❒	Endocrine, Thyroid, Gland Problems	
❒	❒	Liver Problems	
❒	❒	Bleeding or Blood Clotting Problems, Anemia	
❒	❒	Kidney, Urinary, or Prostate Problems	
❒	❒	Gastrointestinal, Bowel Problems	
❒	❒	Musculoskeletal, Breaks / Fractures, Arthritis	
❒	❒	Back Pain	
❒	❒	Obstetrical, Gynecological	
❒	❒	Chronic Fatigue Syndrome	
❒	❒	Dermatologic, Skin Problems, Skin Cancer	
❒	❒	Cancers, Malignancy	
❒	❒	Sexually Transmitted Disease	
❒	❒	Anorexia / Bulimia, Dietary Medications, Weight Loss Medications / Restrictions	
❒	❒	Recent Medical Problem / Infection In The Last 7 Days	
❒	❒	Other	

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

1. UCLAH: UCLA Health (UCLAH) is part of the University of California and is comprised of its hospital(s), medical center(s), its hospital-based clinics, its Primary Care Network clinics, the UCLA Medical Group; and the David Geffen School of Medicine.

2. MEDICAL CONSENT: I consent to medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping, laboratory procedures, and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. I also consent to my admission to the UCLA Medical Centers if this is necessary for my care.

3. TEACHING, RESEARCH AND HEALTHCARE INSTITUTION: The University of California including UCLAH, is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the University's medical education programs. Some UCLAH faculty are identified by their name badge as "Visiting Professors". These faculty members do not have a California license, but are licensed in another state or country. These physicians are permitted to practice medicine in California under a special program developed by the Medical Board of California.

I also understand that a University institutional review board approves projects conducted by University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

4. USE OF MEDICAL INFORMATION AND SPECIMENS: I understand that my medical information, photographs, and/or video in any form may be used for other UCLAH purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that UCLAH may collect during the course of my treatment and care may be used and shared with researchers. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research. I further understand that any use of my medical information or Specimens by UCLAH or other research institutions will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the UCLAH Notice of Privacy Practices.

5. PERSONAL VALUABLES: UCLAH maintains fireproof safes for the safekeeping of money and valuables. UCLAH shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs or other articles of unusual value and shall not be liable for loss or damage to any personal property, unless deposited in a safe or locked storeroom. The liability for loss of any personal property deposited with UCLAH shall be no more than $500.

TERMS AND CONDITIONS OF SERVICE CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

6. RELEASE OF MEDICAL INFORMATION: The State of California Information Practices Act requires UCLAH to provide the following information to individuals who supply information about themselves. As a patient of UCLAH, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UCLAH is authorized to maintain this information. As required by UCLAH, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

UCLAH will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCLAH is permitted or required by law to release information (see UCLAH' Notice of Privacy Practices for a description of the specific circumstances under which UCLAH may release this information). For example, UCLAH may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, including but not limited to cancer, HIV, tuberculosis, and viral meningitis, UCLAH is required by law to report my diagnosis to governmental organizations such as the State Department of Health Services or the Center for Disease Control and Prevention.

7. FINANCIAL AGREEMENT: I understand that even if I have insurance. I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay The Regents of the University of California for professional, hospital and clinic services, including UCLAH physician services, in accordance with the regular rates and terms of UCLAH. I also agree to pay for other professional services provided at UCLAH by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

8. ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and direct payment to UCLAH of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCLAH services, including emergency services, at a rate not to exceed UCLAH actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UCLAH by me.

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

NOTICE TO CONSUMERS: Medical doctors, including your physician, are licensed and regulated by the Medical Board of California. For information you may call the Board at (800) 633-2322 or visit its website at http://www.mbc.ca.gov.

I have read, agreed to and received a copy of this Terms and Conditions of Service.

______________________________ ____________ ____________
Signature of Patient or Patient Representative   Date   Time

____
Relationship of Representative to Patient

______________________________ ____________ ____________
Signature of Witness (required if patient unable to sign)   Date   Time

______________________________ ____________ ____________
Signature of Interpreter   Date   Time

____________________ ________________________
Interpreter ID #   Language Used

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 7) and Assignment Of Benefits (Including Medicare Benefits) (Paragraph 8) set forth above.

________ ________ ____________________ ____________________
Date   Time   Financially Responsible Party   Witness

PATIENT RIGHTS NOTICE: (applies to inpatient admissions only)

Would you like your agent under a durable power of attorney for health care or your next of kin to receive a copy of the Patient Rights and Responsibilities Notice? If so, please contact the Patient Affairs Department at (310) 267-9113.

ADVANCED DIRECTIVES:

I have an advance directive for health care (e.g., Power of Attorney for Health Care). Yes ☐ No ☐
I have provided UCLAH with a current copy of my advance directive. Yes ☐ No ☐

If "No", I understand it is my responsibility to provide UCLAH a current copy of my advance directive. If I want to express my health care wishes, I understand I should speak to my health care provider.

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

PRIVACY NOTICE - FINANCIAL AND MEDICAL RECORDS

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University Hospitals to provide the following information to individuals who supply information about themselves:

The principal purpose for requesting the information is to assure accurate identification and continuity of medical care, and payment therefore, from whatever source. University policy, California Administrative Code Title 22, Division 5, *Licensing and Certification of Health Facilities and Referral Agencies,* and federal statutes authorize our maintenance of this information.

Furnishing all information requested is mandatory unless otherwise noted. Failure to provide such information may affect your medical care and/or any insurance benefits and coverage. This information may be provided: to your referring physician or other health care professionals involved in your medical care; to others to the extent required in connection with collection of accounts or a claim for aid, insurance or medical assistance to which you may be entitled; to University faculty and students for research and educational purposes; and may be released as provided by state and federal law. The privacy of your record will be safeguarded.

Individuals have the right to review their own records, in accordance with the Information Practices Act and University policy. Information on these policies can be obtained from the officials responsible for maintaining the information:

Your medical record is maintained by:

Westwood Campus
Department Head-Medical Records
UCLA Medical Center/Los Angeles, CA 90095
Phone: (310) 825-6021

Santa Monica Campus
Department Head-Medical Records
UCLA Medical Center/Santa Monica, CA 90404
Phone: (424) 259-8045

Your patient billing information is maintained by:

Westwood / Santa Monica Campuses
Department Head-Patient Accounts
UCLA Medical Center/Los Angeles, CA 90095
Phone: (310) 825-8021

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

PRIVACY NOTICE - SOCIAL SECURITY NUMBER

The University system of records that requires the social security number was in existence and operating before January 1, 1975, under the authority of the Regents of the University of California. Article IX, Section 9, of the California Constitution. The disclosure is required by law or University procedure in effect prior to that date to verify the identity of the individual.

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. It is used to verify your identity in the medical care, and payment system. Disclosure of the social security number is required pursuant to regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II, of the Social Security Act, as amended.

PRIVACY NOTICE - CANCER REPORTING

If, during your care at UCLA Medical Centers you have cancer diagnosed, UCLA Medical Centers must by State law (Chapter 841, Statutes of 1985) report this to the regional cancer registry. This information is being collected to help identify preventable causes of cancer, and includes specific details of the type of cancer and the treatment provided as well as information about you such as your name, age, sex, ethnicity, occupation, religion, address and social security number.

The information reported is confidential under California Health and Safety Codes, Section 211.3 and 211.5, and safeguards are in place throughout the system to ensure that your identity will not be unlawfully revealed. Some cancer patients may be contacted later by the California Department of Health Services or the regional cancer registries as part of their ongoing investigations into the causes of cancer.

UCLA Health

MRN:

Patient Name:

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

UNIVERSITY OF CALIFORNIA LOS ANGELES (UCLA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

UCLA HEALTH

UCLA Health is one of the health care components of the University of California. The University of California health care components consist of the UC medical centers, the UC medical groups, clinics and physician offices, the UC schools of medicine and other UC health professions schools engaged in clinical care, the student health service areas on some campuses, employee health units on some campuses, and the administrative and operational units that are part of the health care components of the University of California.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

UCLA Health is committed to protecting medical, mental health and personal information about you ("Health Information"). We are required by law to maintain the privacy of your Health Information, provide you information about our legal duties and privacy practices, inform you of your rights and the ways in which we may use Health Information and disclose it to other entities and persons.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following sections describe different ways that we may use and disclose your Health Information. Some information, such as certain drug and alcohol information, HIV information, genetic information and mental health information is entitled to special restrictions related to its use and disclosure. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories. Other uses and disclosures not described in this Notice will be made only if we have your written authorization.

For Treatment. We may use Health Information about you to provide you with medical and mental health treatment or services. We may disclose Health Information about you to doctors, nurses, technicians, students, or other health system personnel who are involved in taking care of you in the health system. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. A doctor treating you for a mental condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed to you. We may also share Health Information about you with other non- UCLA

Health providers. The disclosure of your Health Information to non-UCLA Health providers may be done electronically through a health information exchange that allows providers involved in your care to access some of your UCLA Health records to coordinate services for you.

For Payment. We may use and disclose Health Information about you so that the treatment and services you receive at UCLA Health or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about surgery or therapy you received at UCLA Health so your health plan will pay us or reimburse you for the surgery or therapy. We may also tell your health plan about a proposed treatment to determine whether your plan will pay for the treatment.

For Health Care Operations. We may use and disclose Health Information about you for our business operations. For example, your Health Information may be used to review the quality and safety of our services, or for business planning, management and administrative services. We may contact you about alternative treatment options for you or about other benefits or services we provide. We may also use and disclose your health information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called “business associates” and are required by law to keep your Health Information confidential. We may also disclose information to doctors, nurses, technicians, medical and other students, and other health system personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at UCLA Health.

Fundraising Activities. We may contact you to provide information about UCLA Health sponsored activities, including fundraising programs and events. We may use contact information, such as your name, address and phone number, date of birth, physician name, the outcome of your care, department where you received services and the dates you received treatment or services at UCLA Health. You may opt-out of receiving fundraising information for the UCLA Health by contacting us at 1-855-364-6945 or by email at OptOutUCLAHSD@Support.ucla.edu.

Hospital Directory. If you are hospitalized, we may include certain limited information about you in the hospital directory. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, such as ministers or rabbis, even if they don’t ask for you by name. You have the opportunity to limit the release of directory information by telling UCLA Health at the time of your hospitalization.

Our disclosure of this information about you if you are hospitalized in a psychiatric hospital will be more limited.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital.

Disaster Relief Efforts. We may disclose Health Information about you to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.

Research. The University of California is a research institution. We may disclose Health Information about you for research purposes, subject to the confidentiality provisions of state and federal law. All research projects involving patients or the information about living patients conducted by the University of California must be approved through a special review process to protect patient safety, welfare and confidentiality.

In addition to disclosing Health Information for research, researchers may contact patients regarding their interest in participating in certain research studies. Researchers may only contact you if they have been given approval to do so by the special review process. You will only become a part of one of these research projects if you agree to do so and sign a specific permission form called an Authorization. When approved through a special review process, other studies may be performed using your Health Information without requiring your authorization. These studies will not affect your treatment or welfare, and your Health Information will continue to be protected.

As Required By Law. We will disclose Health Information about you when required to do so by federal or state law.

To Prevent a Serious Threat to Health or Safety. We may use and disclose Health Information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your Health Information to organizations that obtain, bank or transplant organs, eyes or tissue, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are or were a member of the armed forces, we may release Health Information about you to military command authorities as authorized or required by law.

Workers' Compensation. We may use or disclose Health Information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health Disclosures. We may disclose Health Information about you for public health activities such as:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;

Abuse and Neglect Reporting. We may disclose your Health Information to a government authority that is permitted by law to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Proceedings. We may disclose Health Information to courts, attorneys and court employees in the course of conservatorship, writs and certain other judicial or administrative proceedings. We may also disclose Health Information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release Health Information:

- To identify or locate a suspect, fugitive, material witness, certain escapees, or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- About criminal conduct at UCLA Health; and
- In case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. We may also disclose medical information about patients of UCLA Health to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. As required by law, we may disclose Health Information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As required by law, we may disclose Health Information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release Health Information about you to the correctional institution as authorized or required by law.

Psychotherapy Notes. *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes have additional protections under federal law and most uses or disclosures of psychotherapy require your written authorization.

Marketing or Sale of Health Information. Most uses and disclosures of your Health Information for marketing purposes or any sale of your Health Information would require your written authorization.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

Other uses and disclosures of Health Information not covered by this Notice will be made only with your written authorization. If you authorize us to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. However, the revocation will not be effective for information that we have already used and disclosed in reliance on the authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Your Health Information is the property of UCLA Health. You have the following rights regarding the Health Information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your Health Information. If we have the information in electronic format then you have the right to get your Health Information in electronic format if it is possible for us to do so. If not we will work with you to agree on a way for you to get the information electronically or as a paper copy.

To inspect and/or to receive a copy of your Health Information, you must submit your request in writing to:

UCLA Health, Health Information Management Services
10833 Le Conte Avenue, CHS BH921
Los Angeles CA 90095-7305

If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to Health Information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by UCLA Health will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that Health Information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for UCLA Health.

Amendment. To request an amendment, your request must be made in writing and submitted to:

UCLA Health - Health Information Management Services
10833 Le Conte Avenue, CHS BH921
Los Angeles CA 90095-7305

You must be specific about the information that you believe to be incorrect or incomplete and you must provide a reason that support the request.

We may deny your request for an amendment if it is not in writing, we cannot determine from the request the information you are asking to be changed or corrected or your request does not include a reason to support the change or addition. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UCLA Health
- Is not part of the Health Information kept by or for UCLA Health;
- Is not part of the information which you would be permitted to inspect and copy; or
- UCLA Health believes to be accurate and complete.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to:

UCLA Health, Health Information Management Services
10833 Le Conte Avenue, CHS BH921
Los Angeles CA 90095-7305

An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

MRN:

Patient Name:

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your Health Information.

To request this accounting of disclosures, you must submit your request in writing to:

UCLA Health, Health Information Management Services
10833 Le Conte Avenue, CHS BH921
Los Angeles CA 90095-7305

Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

To request a restriction, you must make your request in writing to:

UCLA Health, Health Information Management Services
10833 Le Conte Avenue, CHS BH921,
Los Angeles CA 90095-7305

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. *We are not required to agree to your request* except in the limited circumstance described below. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency care.

We are required to agree to a request not to share your information with your health plan if the following conditions are met:

1. We are not otherwise required by law to share the information
2. The information would be shared with your insurance company for payment purposes;
3. You pay the entire amount due for the health care item or service out of your own pocket or someone else pays the entire amount for you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your Health Information in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

To request confidential medical communications, you must make your request in writing to:

UCLA Health, Health Information Management Services
10833 Le Conte Avenue, CHS BH921
Los Angeles CA 90095-7305

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available throughout UCLA Health, or you may obtain a copy at our website, http://www.uclahealth.org.

Right to be Notified of a Breach. You have the right to be notified if we or one of our Business Associates discovers a breach of unsecured Health information about you.

CHANGES TO UCLA HEALTH'S PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change UCLA Health System's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice throughout UCLA Health. In addition, at any time you may request a copy of the current Notice in effect.

QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact:

Office of Compliance Services – Privacy
924 Westwood Boulevard, Suite 520
Los Angeles CA, 90024-2929 or (310) 794-8638.

If you believe your privacy rights have been violated, you may file a complaint with UCLA Health or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a written complaint with UCLA Health contact:

Office of Compliance Services – Privacy
924 Westwood Boulevard, Suite 520
Los Angeles CA, 90024-2929

You will not be penalized for filing a complaint.

UCLA Health

MRN:

Patient Name:

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

The UCLA Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we are providing you, copies of the current notice are available by accessing our website at www.uclahealth.org and may be obtained throughout the UCLA Health.

I acknowledge that I have received the Notice of Privacy Practices.

______________________________ ______________ ________
Signature of Patient or Patient's Representative Date Time

______________________________ ______________
Print Name Relationship to Patient

______________________________ ______________
Interpreter (if applicable) Interpreter ID #

COMPLETE IF WRITTEN ACKNOWLEDGMENT WAS NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained (please initial).

1. ________ Notice of Privacy Practices Given – Patient Unable to Sign
2. ________ Notice of Privacy Practices Given – Patient Declined to Sign
3. ________ Notice of Privacy Practices and Acknowledgment Mailed to Patient
4. Other Reason Patient Did Not Sign: ______________________________

______________________________ ______________ ________
Signature of UCLA Health Representative Date Time

______________________________ ______________
Print Name Department