UCLA Health

MRN:
Patient Name:

AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

Patient Name: _____ MRN: _____

Date of Birth: _____ SSN – Last Four Digits Only: _____

I authorize UCLA Health to release PHI to:

Name of person/ facility to **receive** PHI: _____

_____

Address: _____

City, State & Zip Code: _____

Request Delivery**:** ☐ **CD** ☐ **E-Mail** ☐ **Paper Copy**

Note: If left blank, a CD will be provided.

E-Mail Address: _____

SPECIFY HEALTHCARE FACILITY FROM WHICH PHI IS REQUESTED

☐ UCLA Health Hospitals	☐ Jules Stein Eye Institute	☐ Resnick Neuropsychiatric Hospital

TYPE OF RECORDS

☐ MEDICAL	☐ MENTAL HEALTH (other than psychotherapy notes)

Information to be RELEASED

☐ Billing Statements	☐ Genetic Testing Information	☐ Pathology Reports
☐ Consultations/Evaluations	☐ HIV/AIDS Test Results	☐ Progress Notes
☐ Dental Records	☐ HIV/AIDS Treatment Information	☐ Psychological/Vocational Test Results
☐ Discharge Summary	☐ History & Physical Exams	☐ Radiology & other diagnostic Images (x-rays, etc.)
☐ Drug & Alcohol Abuse Information	☐ Laboratory Reports	☐ Radiology & other Diagnostic Reports
☐ EKG	☐ Outpatient Clinic Records	
☐ Emergency Medicine Reports	☐ Operative Reports	
☐ Other		

SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE:

FROM MM / DD / YYYY TO MM / DD / YYYY

THE PURPOSE OF THIS RELEASE IS (check one or more)

☐ At the request of the patient/patient representative

☐ Other (state reason) _____

UCLA Health

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NOTICE

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

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 may revoke this authorization at any time, provided that I do so in writing and submit it to the:
  Health Information Management Services – UCLA Health
  10833 Le Conte Avenue, CHS BH-225,
  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.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date). If no date is indicated, this Authorization will expire 12 months after the date signed.

SIGNATURE

_____ Date: _____
(Signature of Patient / Legal Representative)

_____ _____
Printed Name Phone Number (Include Area Code)

(If signed by someone other than the patient, indicate relationship to the patient) _____

_____ Date: _____
Signature of Witness
(only if patient unable to sign) or Interpreter | Interpreter ID #: _____

☐ Please check box for medical records ☐ Please check box for radiology images

UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-225 Los Angeles, CA. 90095-78305 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. 90095-78305 Fax 310-825-3205 Phone 310-825-6425