UCLA Health

AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

Medical Record Number:
Patient Name:
Birth Date:
SSN (Last Four Digits – Only):

I authorize _____ to release PHI to:
(name of person/ facility which has information)
Name of person/ facility to **receive** PHI: _____

_____

Address: _____

City, State & Zip Code:

I would like to: ☐ request a **PAPER** copy **-OR-** ☐ request an **ELECTRONIC** copy (CD)

SPECIFY HEALTHCARE FACILITY FROM WHICH PHI IS REQUESTED

☐ Ronald Reagan UCLA Medical Center	☐ UCLA Medical Center Santa Monica
☐ Resnick Neuropsychiatric Hospital	☐ Semel Neuropsychiatric Institute
☐ Home Health	☐ Jules Stein Eye Institute
☐ Clinic _____ (Specify Name of Clinic)	

TYPE OF RECORDS

☐ **MEDICAL**	☐ MENTAL HEALTH (other than psychotherapy notes)

Information to be RELEASED

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

SPECIFY DATE/ TIME PERIOD FOR INFORMATION SELECTED ABOVE:

_____

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

☐ At the request of the patient/patient representative
☐ Other (state reason) _____

Initials of Patient or Legal Representative: _____

Patient Name:
Birth Date:
SSN (Last Four Digits – Only):

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NOTICE

UCLA Health System 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) to obtain information in connection with eligibility or enrollment in a health plan,
  3) to determine an entity's obligation to pay a claim, or
  4) to create 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 System, 10833 Le Conte Avenue, CHS BH-225, Los Angeles, CA 90095-7305. The revocation will take effect when UCLA Health System receives it, except to the extent that UCLA Health System 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 or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE

_____ Date: _____ Time: _____AM / PM
(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: _____ Time: _____AM / PM
Signature of Witness
(only if patient unable to sign) or Interpreter