UCLA Health System

Authorization for Release of Health Information

Medical Record Number:

Patient Name:

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

I authorize _____ to release health information to:
(*name of person or facility which has information*)

_____

Name of person or facility to **receive** health information

_____

Specify name/title of person to receive health information, if known

_____

Street Address, City, State, Zip Code

SPECIFIC HEALTHCARE FACILITY FROM WHICH HEALTH INFORMATION IS REQUESTED

☐ UCLA RONALD REAGAN MEDICAL CENTER (Westwood) ☐ CLINIC _____	☐ SANTA MONICA UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL ☐ CLINIC _____
☐ RESNICK NEUROPSYCHIATRIC HOSPITAL	☐ JULES STEIN EYE INSTITUTE
☐ SEMEL NEUROPSYCHIATRIC INSTITUTE	
☐ CLINIC _____ SPECIFY NAME OF CLINIC	
☐ HOME HEALTH	

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 and other Diagnostic Reports
☐ EKG ☐ Progress Notes ☐ Drug and Alcohol Abuse Information	☐ Radiology and other Diagnostic Images (x-rays, etc.) ☐ HIV/AIDS Test Results ☐ HIV/AIDS Treatment Information	☐ Consultations/Evaluations ☐ Outpatient Clinic Records ☐ Genetic Testing Information ☐ Psychological/Vocational Test Results
☐ Other _____		

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE:

_____

Initials of Patient or Personal Representative: _____

Medical Record Number:

Patient Name:

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

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

NOTICE

UCLA Health System 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.

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 health information 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 BH265, 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: _____
(Signature of Patient or Patient's Legal Representative)

_____ Time: _____AM / PM
Printed Name

_____
Phone Number (Include Area Code)

_____
(*if signed by someone other than the patient, state your relationship to the patient/authority*)

_____
Witness (*only if patient unable to sign)* or Interpreter