UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Patient Information	Patient Name: ______________________________ MRN: ______________ Address: ____ City, State & Zip Code: ____ Date of Birth (MMDDYYYY): _______________ Phone: (____) _______________
Specify Healthcare Facility	☐ UCLA Health Hospitals/Clinics ☐ Jules Stein Eye Institute ☐ Resnick Neuropsychiatric Hospital
Release Records to *Where do you want records sent?* *Who do you want to receive records?*	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**
Delivery Instructions *(please select one)*	☐ CD ☐ E-Mail (NPH/BHS does not release via email) ☐ Paper Copy ☐ Call Requestor when records are ready for pick up **Note:** If left blank, a CD will be provided.
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☐ Other (state reason) ____

Health Information to be Released: *What records are being requested?*

Type of Records:

☐ Medical Records	☐ Mental Health (other than psychotherapy notes)	
☐ Billing Statements	☐ Emergency Reports (ER)	☐ Pathology Reports
☐ Consultations	☐ History & Physical Exams	☐ Progress Notes
☐ Discharge Summary	☐ Jules Stein Images	☐ Radiology Images (x-rays)
☐ EEG Video	☐ Laboratory Reports	
☐ EKG	☐ Operative Reports	☐ Radiology Reports
☐ Other:		

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Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results
Specify Date/Time Period	SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE: FROM MM / DD / YYYY TO MM / DD / YYYY
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 signed.
Signature(s)	______________________________ ______________ (Signature of Patient / Legal Representative) Date ______________________________ ______________ Printed Name Area Code/Phone Number If signed by someone other than the patient, indicate relationship to the patient ______________________________ ______________________________ ______________ Signature of Witness (only if patient unable to sign) or Interpreter | Interpreter ID #____________ Date

Mailing Addresses

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

☐ Please check box for mental health records

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

Release of Information Customer Service – Walk-in Service

Open Hours 8a-4:30pm **Closed Lunch** 11:30a-12:30p	**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
	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

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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.