UCLA Healthcare

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Medical Record Number: _____

Patient Name: _____

Birth Date: _____ SSN: _____

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

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

***SPECIFY THE DATE OR 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 Personal Representative:*_____

L:\HIPAA\Authorization\UCLA Authorization
Revised: 03/11/03 08/14/03 12/18/03

Medical Record Number: _____

Patient Name: _____

***UCLA HEALTHCARE***

***NOTICE***

UCLA Healthcare 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 of eligibility for benefits may not be conditioned on signing this authorization except if the authorizations 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 Privacy Management Office, UCLA Healthcare, 10833 Le Conte, CHS BH265, Los Angeles, CA 90095-7305. The revocation will take effect when UCLA Healthcare receives it, except to the extent the UCLA Healthcare or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

***EXPIRATION OF AUTHORIZATION***

Unless otherwise revoked, the 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

_____

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

_____

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