

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

MRN: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (Patient Label)

<p><b>Patient Information</b></p>	<p>Patient Name _____ Medical Record # _____                  Street Address: _____                  City, State &amp; Zip Code: _____                  Date of Birth (MMDDYYYY): _____ Phone: (____) _____                  E-Mail Address: _____</p>																					
<p><b>Specify Healthcare Facility</b></p>	<p><input type="checkbox"/> UCLA Health Hospitals/Clinics Doctor/Clinic _____  <input type="checkbox"/> Jules Stein Eye Institute  <input type="checkbox"/> Resnick Neuropsychiatric Hospital</p>																					
<p><b>Release Records to</b> <i>Where do you want records sent?</i></p>	<p>I authorize <b>UCLA Health</b> to release PHI to:                  Name of Hospital/Clinic/Person: _____                  Street Address: _____                  City, State &amp; Zip Code: _____                  Phone: (____) _____ FAX: (____) _____                  *E-Mail Address: _____  <b>*Note: Provide your email address to receive an email status of your request.</b></p>																					
<p><b>Delivery Instructions</b> <i>(please select one)</i></p>	<p><input type="checkbox"/> CD    <input type="checkbox"/> E-Mail    <input type="checkbox"/> Paper Copy                  (Neuropsychiatric Hospital/Behavioral Health Sciences does not release via email)  <b>Note:</b> If left blank, a CD will be provided.                  *See page 2 for myUCLAhealth information</p>																					
<p><b>Purpose</b> <i>What is the purpose of this release?</i></p>	<p><input type="checkbox"/> At the request of the patient/patient representative  <input type="checkbox"/> Other (state reason)                  _____</p>																					
<p><b>Health Information to be Released:</b> <i>What records are being requested?</i></p>	<p><b>Type of Records:</b></p> <table border="1" data-bbox="367 1472 1537 1766"> <tr> <td><input type="checkbox"/> Clinic Visit (office notes &amp; consultations)</td> <td><input type="checkbox"/> Emergency Reports (ER)</td> <td><input type="checkbox"/> Pathology Reports</td> </tr> <tr> <td><input type="checkbox"/> Billing Statements</td> <td><input type="checkbox"/> History &amp; Physical Exams</td> <td><input type="checkbox"/> Progress Notes</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Jules Stein Images</td> <td rowspan="2"><input type="checkbox"/> Radiology Images (x-rays)</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Laboratory Reports</td> </tr> <tr> <td><input type="checkbox"/> EEG Video</td> <td><input type="checkbox"/> Operative Reports</td> <td><input type="checkbox"/> Radiology Reports</td> </tr> <tr> <td><input type="checkbox"/> EKG</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td></td> <td></td> </tr> </table> <p><input type="checkbox"/> Mental Health (Neuropsychiatric Hospital &amp; Clinic Records)</p>		<input type="checkbox"/> Clinic Visit (office notes & consultations)	<input type="checkbox"/> Emergency Reports (ER)	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Billing Statements	<input type="checkbox"/> History & Physical Exams	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Consultations	<input type="checkbox"/> Jules Stein Images	<input type="checkbox"/> Radiology Images (x-rays)	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> EEG Video	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> EKG			<input type="checkbox"/> Other:		
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<b>Sensitive Information</b>	<p><b>Sensitive information will not be released unless specifically authorized below:</b></p> <p> <input type="checkbox"/> Drug and Alcohol Abuse Results      <input type="checkbox"/> Genetic Testing Information  <input type="checkbox"/> HIV/AIDS Test Results      <input type="checkbox"/> Psychological/Vocational Results         </p>
<b>Specify Date/Time Period</b>	<p>ESTIMATE/SPECIFY DATE RANGE FOR RECORDS BEING REQUESTED:</p> <p>FROM MM / DD / YYYY TO MM / DD / YYYY</p>
<b>Expiration of Authorization</b>	<p>Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event).</p> <p>If no date is indicated this Authorization will expire 12 months after the date signed.</p>
<b>Signature(s)</b>	<p>_____</p> <p>(Signature of Patient / Legal Representative)      Date _____</p> <p>_____</p> <p>Printed Name      Area Code/Phone Number _____</p> <p>If signed by someone other than the patient, indicate relationship to the patient _____</p> <p>_____</p> <p>Signature of Witness (only if patient unable to sign)      Date _____          or Interpreter      Interpreter ID # _____</p>

<b>Mailing Addresses</b>	
<p><b>UCLA HIMS, Release of Information</b>          10833 Le Conte Ave, CHS BH-902          Los Angeles, CA 90095-1776          Fax: (310) 983-1468   Phone: (310) 825-6021          Email: <a href="mailto:roi@mednet.ucla.edu">roi@mednet.ucla.edu</a></p>	<p><b>Image Management, Release of Information</b>          200 Medical Plaza          B1- Level   Suite 165-11          Los Angeles CA 90095          Fax 310-825-3205   Phone 310-825-6425</p>
<p><b>Mental Health Records</b>          RNPH/BHS HIMS          10833 Le Conte Ave BH239A          Los Angeles CA 90095          Fax 310-206-7682          Phone 310-267-2661 or 310-794-1530          Email: <a href="mailto:NPHROI@mednet.ucla.edu">NPHROI@mednet.ucla.edu</a></p>	<p><b>Request medical records via myUCLAhealth.</b></p> <p><b>Visit our website for information:</b>  <a href="https://www.uclahealth.org/medical-records">https://www.uclahealth.org/medical-records</a></p> <p><b>For assistance with your myUCLAhealth account, call: 855-364-7052.</b></p>

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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.

**Requesting records using the UCLA Health patient portal is available for patients and their proxies. Visit myUCLAhealth at:**

**<https://www.uclahealth.org/medical-records>**

**For assistance with your myUCLAhealth account, call: 855-364-7052**