Section A This section must be completed for all Authorizations

Patient Name:	Date of Birth:	Patient's Phone:	Last 4-digit SSN (optional)
Provider's Name:	Recipient's Name:		

Please return completed authorization to: HIM UCLA
West Valley Medical Center
7300 Medical Center Dr. West Hills CA, 91307
Fax: (205) 588-1892.
Email: ROIWestValley@mednet.ucla.edu

Address 1:		
Address 2:	Recipient's Phone:	
City:	State:	Zip:

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Electronic Media, if available (e.g., USB drive, CD/DVD, eDelivery)
☐ Encrypted Email ☐ Unencrypted Email
NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ No, then you may check as many items below as you need
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ ABSTRACT only		☐ Medication sheets		☐ Labor/delivery summary	
☐ My entire medical record (all PHI)		☐ Operative information		☐ OB nursing assess	
☐ Admission form		☐ Cath lab		☐ Postpartum flow sheet	
☐ Dictation reports		☐ Special test/therapy		☐ Itemized bill:	
☐ Provider orders		☐ Rhythm strips		☐ UB-04:	
☐ Intake/outtake		☐ Nursing information		☐ Other:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
		☐ ED information			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results, or AIDS information. (Initial): _____

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ NO
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ YES ☐ NO If yes, describe:
May recipient of the PHI further exchange the information for financial remuneration? ☐ YES ☐ NO

Section C Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Printed Name of Patient or Authorized Representative

Relationship | Patient Signature or Authorized Representative | Date/Time

UCLA Health
UCLA West Valley Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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