

COMMUNICATIONS | MARKETING AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI):

MRN:		
Patient Name:		

PROTECTED HEALTH INFORMATION (PHI):
UCLA Health is committed to protecting the privacy of our patients. That is why we must obtain your written consent before we may reveal details about you, or your ward's care.
Participant:Date of Birth:/
Address:(City, State, Zip) Phone Number: ()Email (optional):
Guardian or Representative (if applicable):
BRIEF DESCRIPTION OF PROJECT
HEALTH INFORMATION DISCLOSED MAY INCLUDE (check all that apply): ☐ Health History ☐ Medical and/or Photo Images ☐ Treatment Information ☐ Diagnosis
Other:
PURPOSE OF PROJECT (check all that apply):
☐ Educational Material ☐ Publication ☐ Media Outreach ☐ Promotional Material
Other:
INFORMATION REGARDING CARE WILL BE GATHERED FROM: ☐ UCLA Health employees involved in the patient's care.
☐ Other:
INFORMATION REGARDING CARE WILL BE DISCLOSED TO: UCLA Health Ucla Media Ucla Other:
I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING (if applicable):
☐ Not Applicable
\square Mental health treatment information NOT including psychotherapy notes
☐ HIV test results and/or HIV treatment information
☐ Alcohol and/or substance abuse treatment information



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LIMITATIONS ON THE USE OF PARTICIPANT'S HEALTH INFORMATION (please be specific):					
DURATION OF AUTHORIZATION This authorization will remain in effect until: / / .					
If no date is listed, this authorization will remain in effect for a period of five (5) years from the date of signature attached.					

DO I HAVE TO SIGN THIS FORM?

may be subject to re-disclosure.

Absolutely not! This authorization to release health information is voluntary. Declining to sign this authorization will not affect you, or your ward's, treatment, payment enrollment, or eligibility for benefits.

UCLA is required by law to keep health information confidential. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it

CAN I RECEIVE A COPY OF THIS AUTHORIZATION?

Yes! You have the right to request and receive a signed copy of this authorization.

WHAT IF I CHANGE MY MIND?

You may revoke this authorization at any time by writing to:

UCLAHealthNews@mednet.ucla.edu

OR

UCLA Health Sciences Media Relations 10960 Wilshire Blvd., Suite 1955 Los Angeles, CA 90025

Because UCLA Health puts a great deal of time and care into conceiving and developing communications and publications, we ask that you write to the address above as soon as possible after deciding to revoke your authorization.

Revocation will be effective upon receipt, except to the extent that UCLA or others have already relied on it. If the multimedia items have already been shared, it may not be possible to recall them.



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I have read this form and all of my questions have been answered. My signature confirms that I understand and accept all of the above conditions and approve the disclosure and use of health information by UCLA Health.

Signature of patient, parent or	conservator	Date	Time
If not signed by patient, indicat	e relationship or guardia	an:	
UCLA Representative Name		UCLA Representative Si	gnature
Date	Time		
I have accurately and comple	_		legal
representative) in the patient	•	nderstood all of the term	ns and
conditions and acknowledge	ed his/her agreement b	y signing the document	in my
presence.			
0: 1 (T		D: (IN CT	
Signature of Translator		Printed Name of Transla	tor
Date	Time	Translator ID #	