UCLA Health

MRN:

Patient Name:

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

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:____

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 ☐ Outside Media ☐ Other:______________________________

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING (if applicable)**:**

☐ Not Applicable

☐ 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.

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 may be subject to re-disclosure.

DO I HAVE TO SIGN THIS FORM?

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.

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
924 Westwood Boulevard, Suite 350
Los Angeles, CA 90024

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, indicate relationship or guardian: ______________________________

______________________________ ______________________________
UCLA Representative Name | UCLA Representative Signature

______________ ______________
Date | Time

I have accurately and completely read this consent to (patient or patient's legal representative) in the patient's or legal representative's primary language ___________________ (identify language). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

______________________________ ______________________________
Signature of Translator | Printed Name of Translator

______________ ______________ ______________
Date | Time | Translator ID #