UCLA HEALTHCARE
DISCLOSURE OF PHI TO A COPY SERVICE

Patient Name _____ MRN _____

DOB _____ Address_____

City _____State _____ Zip _____

Name of Copy Service _____

Copy Service Representative _____

Date of Request _____**Dated Received**: _____

Date PHI Released to Copy Service_____

Purpose of Release _____

Clinic/Department/Primary Care Network_____

UCLA Healthcare Representative _____

UCLA Healthcare Representative Phone _____ Pager_____

Attach copy of Subpoena or complete the shaded box below:

PHI Requestor _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax_____

PHI Destination Contact _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax:_____

Authorization for Disclosure:

☐ Court Order
☐ Patient/Legal Representative
☐ Search Warrant
☐ Special Master
☐ Subpoena

Type of Subpoena (if applicable):

☐ Criminal
☐ Civil
☐ Work Comp

☐ Case Number (if applicable)_____

Request Category:

☐ Attorney_____
☐ Insurance Company
☐ Subpoena
☐ Court Order
☐ Workers Comp
☐ Other

Specify All Items Copied by Copy Service:

Item Type	Date From	Date To	# of items Disclosed	Notes

(Forward to the Privacy Management Office, UCLA Healthcare, 10833 Le Conte Avenue, Room CHS BH-265 Los Angeles, CA 90095-7305 Fax: 310-206-2820)