UCLA Healthcare

MR#

Name

DOB

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR FUNDRAISING

I authorize UCLA Healthcare to release my protected health information to (specify the name (s), or other identify of the person(s) or class or group of person(s)):

_____

_____

Street Address (If applicable) City, State, Zip Code (If Applicable) Phone Number (If Applicable)

PLEASE SPECIFY THE PROTECTED HEALTH INFORMATION YOU AUTHORIZE TO BE RELEASED:

Type (s) of health information:_____

Date (s) of treatment:_____

The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare & Institutions Code §§ 5328, *et seq.)*

_____ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).

_____ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

THE PURPOSE OF THE RELEASE OF YOUR PROTECTED HEALTH INFORMATION IS FOR (check one or more):

Fundraising activities to raise money to support the activities and programs of UCLA Healthcare

Other (specify)_____

NOTICE: UCLA Healthcare 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 be subject to re-disclosure and may no longer be protected by state or federal confidentiality laws. This Authorization to release health information is voluntary. You are not required to sign this authorization in order to receive treatment, for payment of your care, or for enrollment in a health plan or eligibility for benefits.

*Initials of Patient or Personal Representative:*_____

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This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to the UCLA Medical Sciences Development Office, 10945 Le Conte Avenue, Suite 3132, Box 951784, Los Angeles, CA 90095-1784. The revocation will take effect when UCLA Healthcare receives it, except to the extent UCLA Healthcare or others have already relied on it. You are entitled to receive a copy of this Authorization. Unless otherwise revoked, this Authorization expires on __ _____.

If no date is indicated, the Authorization will expire 5 years after the date of your signing this form.

Printed Name	**Signature** (Patient, Parent, Guardian)	**Date** **Time**
Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)	**Witness** (if patient unable to sign) or **Interpreter**	**Phone Number**

Mailing Address: _____

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