UCLA Health

MEDIA & COMMUNITY RELATIONS AUTHORIZATION

MRN:

Patient Name:

(Patient Label)

I authorize UCLA Health to release my protected health information to:

_____

(Specify the name(s), or otherwise identify the person(s) or class or group of person(s), such as a media organization)

_____

Street Address (if applicable)

_____

City, State, Zip (if applicable)

_____

Phone Number (if applicable)

AUTHORIZATION AND PURPOSE:

I voluntarily give my permission for (check one or both):

☐ Photographs, film or videotape of me being taken and used by UCLA Health System staff, the news media or their representatives for the communication of events, programs, procedures at UCLA Health.

☐ Health information regarding my medical condition or treatment to be released to the news media, UCLA Health System staff or their representatives for news stories or other public relations communications (TV, radio, newspapers, magazines, health web sites, or video news release). Please specify the health information you authorize for release:

- o Type(s) of health information: _____
- o Date(s) of treatment: _____

NOTICE:

UCLA Health 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 redisclosure and no longer be protected by state or federal confidentially laws.

YOUR RIGHTS:

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 ineligibility for benefits.

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The following information will not be released unless you specifically authorize it by initialing the relevant lines(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))

Initials of Patient or Personal Representative: _____

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: UCLA Health Sciences Media Relations, 924 Westwood Blvd, Suite 350, Los Angeles, CA 90095. The revocation will take effect when UCLA Health receives it, except to the extent that UCLA Health or others have already relied upon 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 12 months after the date of your signing this form.

_____
Print 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 Interpreter ID #

Mailing Address:

_____