UCLA Healthcare

REQUEST BY PATIENT FOR ACCESS TO THEIR PROTECTED HEALTH INFORMATION

NAME: ____

ADDRESS:____

Phone Number: _____________Date of Birth:________________ Date:______________

I would like to ☐ access my Protected Health Information maintained by UCLA Healthcare
☐ obtain a copy of my Protected Health Information

The specific information I would like to access or receive a copy of is as follows:

☐ Discharge Summary	☐ Laboratory Reports	☐ Emergency Medicine Reports
☐ Billing Statements	☐ Dental Records	☐ History & Physical Exams
☐ Pathology Reports	☐ Operative Reports	☐ Diagnostic Imaging Reports
☐ EKG	☐ Radiology Reports	☐ Consultations
☐ Progress Notes	☐ Entire Record	☐ Outpatient Clinic Records
☐ Other ____		

I want to access my PHI that covers the following time period:

____

☐ Please notify me when the information is ready to be reviewed
☐ Please notify me when the information is ready to be picked up at
☐ Please send the copies of my record to me at the above address
☐ Please send the copies of my record to me at the following address:

____

____

Signature of patient or representative Date

Relationship to patient (if representative:____________________________________

(Forward to the Privacy Management Office, UCLA Healthcare, 10833 Le Conte Avenue, Los Angeles, Ca 90095-7305)