

MRN: _____
 Patient Name: _____

**AUTHORIZATION FOR RELEASE OF (PHI)
 PROTECTED HEALTH INFORMATION**

I authorize _____ to release PHI to:
 (name of person/ facility which has information)
 Name of person/ facility to **receive** PHI: UCLA Cardiology - Dr. Jessica Wang/Judy Fan (Genetic Counselor) 310.206.6516 phone; 310.825.9013 fax
 Address: 100 UCLA Medical Plaza Ste 630 East
 City, State & Zip Code: Los Angeles, CA 90095

I would like to: request a **PAPER** copy -OR- request an **ELECTRONIC** copy (CD)

SPECIFY HEALTHCARE FACILITY FROM WHICH PHI IS REQUESTED

<input type="checkbox"/> Ronald Reagan UCLA Medical Center	<input type="checkbox"/> UCLA Medical Center Santa Monica
<input type="checkbox"/> Resnick Neuropsychiatric Hospital	<input type="checkbox"/> Semel Neuropsychiatric Institute
<input type="checkbox"/> Home Health	<input type="checkbox"/> Jules Stein Eye Institute
<input type="checkbox"/> Clinic _____ (Specify Name of Clinic)	

TYPE OF RECORDS

MEDICAL **MENTAL HEALTH** (other than psychotherapy notes)

Information to be RELEASED

<input type="checkbox"/> Billing Statements	<input checked="" type="checkbox"/> Genetic Testing Information	<input type="checkbox"/> Pathology Reports
<input checked="" type="checkbox"/> Consultations/Evaluations	<input type="checkbox"/> HIV/AIDS Test Results	<input checked="" type="checkbox"/> Progress Notes
<input type="checkbox"/> Dental Records	<input type="checkbox"/> HIV/AIDS Treatment Information	<input type="checkbox"/> Psychological/Vocational Test Results
<input type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> History & Physical Exams	<input checked="" type="checkbox"/> Radiology & other diagnostic Images (x-rays, etc.)
<input type="checkbox"/> Drug & Alcohol Abuse Information	<input checked="" type="checkbox"/> Laboratory Reports	<input checked="" type="checkbox"/> Radiology & other Diagnostic Reports
<input checked="" type="checkbox"/> EKG	<input checked="" type="checkbox"/> Outpatient Clinic Records	
<input type="checkbox"/> Emergency Medicine Reports	<input checked="" type="checkbox"/> Operative Reports	
<input type="checkbox"/> Other _____		

SPECIFY DATE/ TIME PERIOD FOR INFORMATION SELECTED ABOVE:

THE PURPOSE OF THIS RELEASE IS (check one or more)

At the request of the patient/patient representative Future Appointment
 Other (state reason) _____

Initials of Patient or Legal Representative: _____

MRN:
Patient Name:

**AUTHORIZATION FOR RELEASE OF (PHI)
PROTECTED HEALTH INFORMATION**

NOTICE

UCLA Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:
 - 1) conducting research-related treatment,
 - 2) obtaining information in connection with eligibility or enrollment in a health plan,
 - 3) determining an entity's obligation to pay a claim, or
 - 4) creating PHI to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Health Information Management Services, UCLA Health, 10833 Le Conte Avenue, CHS BH-225, Los Angeles, CA 90095-7305. The revocation will take effect when UCLA Health receives it, except to the extent that UCLA Health or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE

_____ Date: _____ Time: _____ AM / PM
(Signature of Patient / Legal Representative)

_____ Printed Name _____ Phone Number (Include Area Code)

(If signed by someone other than the patient, indicate relationship to the patient)

_____ Date: _____ Time: _____ AM / PM
Signature of Witness
(only if patient unable to sign) or Interpreter

Please check box for medical records

Please check box for radiology images

<p>UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-225 Los Angeles, CA. 90095-78305 Fax: (310) 983-1468 Phone: (310) 825-6021</p>	<p>Image Management, Release of Information 200 Medical Plaza B1- Level Suite 165-11 Los Angeles Ca. 90095-78305 Fax 310-825-3205 Phone 310-825-6425</p>
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