



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Medical Record Number: _____

Patient Name: _____

Birth Date: _____ SSN: _____

I authorize _____ to release health information to:
(name of person or facility which has information)

 Name of person or facility to receive health information

 Specify name/title of person to receive health information, if known

 Street Address, City, State, Zip Code

TYPE OF RECORDS

MEDICAL

MENTAL HEALTH (other than psychotherapy notes)

INFORMATION TO BE RELEASED

Discharge Summary

Laboratory Reports

Emergency Medicine Reports

Billing Statements

Dental Records

History & Physical Exams

Pathology Reports

Operative Reports

Radiology and other Diagnostic Reports

EKG

Radiology and other Diagnostic Images (x-rays, etc.)

Consultations/Evaluations

Progress Notes

HIV/AIDS Test Results/Treatment Information

Outpatient Clinic Records

Drug and Alcohol Abuse Information

Genetic Testing Information

Psychological/Vocational Test Results

Other _____

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE:

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

At the request of the patient/patient representative

Other (state reason) _____

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 Representative: _____

Initials of Patient or Personal

Medical Record Number:

Patient Name:

UCLA HEALTHCARE

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 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) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information 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 Privacy Management Office, UCLA Healthcare, 10833 Le Conte Avenue, CHS BH265, Los Angeles, CA 90095-7305. The revocation will take effect when UCLA Healthcare receives it, except to the extent that UCLA Healthcare 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

(Signature of Patient or Patient's Legal Representative)

Date: _____

Printed Name

Time: _____ AM / PM

(*if signed by someone other than the patient, state your relationship to the patient/authority*)

Witness (*only if patient unable to sign*) or Interpreter