



Authorization for Release of Health Information

Medical Record Number: _____

Patient Name: _____

Birth Date: _____ SSN: _____
(Last Four Digits – Only)

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

RECORDS DEPOSITION SERVICE

Name of person or facility to receive health information _____

Specify name/title of person to receive health information, if known Telephone: **248 – 357 – 3330**
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 Fax: **248 – 357 – 3337**

Street Address, City, State, Zip Code _____

SPECIFIC HEALTHCARE FACILITY FROM WHICH HEALTH INFORMATION IS REQUESTED

<input checked="" type="checkbox"/> UCLA RONALD REAGAN MEDICAL CENTER (Westwood)	<input type="checkbox"/> SANTA MONICA UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL
<input type="checkbox"/> CLINIC _____	<input type="checkbox"/> CLINIC _____
<input type="checkbox"/> RESNICK NEUROPSYCHIATRIC HOSPITAL	<input type="checkbox"/> JULES STEIN EYE INSTITUTE
<input type="checkbox"/> SEMEL NEUROPSYCHIATRIC INSTITUTE	
<input type="checkbox"/> CLINIC _____	SPECIFY NAME OF CLINIC _____
<input type="checkbox"/> HOME HEALTH	

TYPE OF RECORDS

MEDICAL MENTAL HEALTH (other than psychotherapy notes)

INFORMATION TO BE RELEASED

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

Other Please see enclosed Subpoena or Letter Request for information to be disclosed. _____

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE:

Initials of Patient or Personal Representative: _____

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

Medical Record Number: Patient Name:

- At the request of the patient/patient representative
 Other (state reason) **FOR DISCOVERY BEFORE TRIAL**

NOTICE

UCLA Health System 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 Health Information Management Services, UCLA Health System, 10833 Le Conte Avenue, CHS BH265, Los Angeles, CA 90095-7305. The revocation will take effect when UCLA Health system receives it, except to the extent that UCLA Health System 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

Phone Number (Include Area Code)

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

Witness (only if patient unable to sign) or Interpreter