UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Patient Information	_____ _____ Patient Name Medical Record # Street Address: _____ City, State & Zip Code: _____ Date of Birth (MMDDYYYY): _____Phone: (____) _____ E-Mail Address: _____
Specify Healthcare Facility	☐ UCLA Health Hospitals/Clinics Doctor/Clinic _____ ☐ Jules Stein Eye Institute ☐ Resnick Neuropsychiatric Hospital
Release Records to *Where do you want records sent?*	I authorize **UCLA Health** to release PHI to: Name of Hospital/Clinic/Person: RECORDS DEPOSITION SERVICE Street Address: P.O. BOX 5054 City, State & Zip Code: SOUTHFIELD, MI 48086-5054 Phone: (248) 357-3330 FAX: (248) 357-3337 *E-Mail Address: REQUESTS@RECDEP.COM *Note: Provide your email address to receive an email status of your request.
Delivery Instructions *(please select one)*	☐ CD ☒ E-Mail ☐ Paper Copy (Neuropsychiatric Hospital/Behavioral Health Sciences does not release via email) **Note:** If left blank, a CD will be provided. *See page 2 for myUCLAhealth information
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☒ Other (state reason) PRE TRIAL DISCOVERY
Health Information to be Released: *What records are being requested?*	**Type of Records:** ☐ Clinic Visit (office notes & consultations)

☐ Billing Statements	☐ Emergency Reports (ER)	☐ Pathology Reports
☐ Consultations	☐ History & Physical Exams	☐ Progress Notes
☐ Discharge Summary	☐ Jules Stein Images	☐ Radiology Images (x-rays)
☐ EEG Video	☐ Laboratory Reports	
☐ EKG	☐ Operative Reports	☐ Radiology Reports
☒ Other: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST		
☐ Mental Health (Neuropsychiatric Hospital & Clinic Records)		

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Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results
Specify Date/Time Period	ESTIMATE/SPECIFY DATE RANGE FOR RECORDS BEING REQUESTED: FROM MM / DD / YYYY TO MM / DD / YYYY
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 signed.
Signature(s)	_____ _____ (Signature of Patient / Legal Representative) Date _____ _____ Printed Name Area Code/Phone Number If signed by someone other than the patient, indicate relationship to the patient _____ _____ _____ Signature of Witness (only if patient unable to sign) or Interpreter Date Interpreter ID #_____

Mailing Addresses	
UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-902 Los Angeles, CA 90095-1776 Fax: (310) 983-1468 | Phone: (310) 825-6021 Email: roi@mednet.ucla.edu	**Image Management, Release of Information** 200 Medical Plaza B1- Level | Suite 165-11 Los Angeles CA 90095 Fax 310-825-3205 | Phone 310-825-6425
Mental Health Records RNPH/BHS HIMS 10833 Le Conte Ave BH239A Los Angeles CA 90095 Fax 310-206-7682 Phone 310-267-2661 or 310-794-1530 Email: NPHROI@mednet.ucla.edu	**Request medical records via myUCLAhealth.** **Visit our website for information: https://www.uclahealth.org/medical-records** **For assistance with your myUCLAhealth account, call: 855-364-7052.**