

Authorization for Release of Medical/Billing Information

Name (Last, First): _____
 Birthdate: _____ UCLA Student ID: _____ Phone: _____
 Email: _____

I authorize: UCLA Arthur Ashe Student Health and Wellness Center to Release PHI to:

Name: Hoosier Services Inc.
 Address: 18032 Lemon Drive, #C-618, Yorba Linda, CA 92886
 Phone: 800.882.4156 Fax: 800.882.4957
 Email: service@hoosierservicesinc.com

Type of Disclosure:

- Verbal Exchange
- Paper Copy Via
 - Mail Fax Pick up (4th Floor, Room 418, Mon-Fri 9am-12pm, 2-4pm)

Please specify the information you authorize to release:

- | | All | or | Dates |
|---|--------------------------|----|----------------------------|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Clinical Notes | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Immunizations Records | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> HIV Test Results (Pick Up Only) | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Lab/X-Ray Reports | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Optometry Records | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Itemized Billing Statement: | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Include CPT Codes (For students with private insurance only) | | | |
| <input type="checkbox"/> Statement of Medication Dispensed: | <input type="checkbox"/> | | ___/___/___ to ___/___/___ |
| <input type="checkbox"/> Include CPT Codes (For students with private insurance only) | | | |
| <input type="checkbox"/> Other: _____ | | | |

This Authorization is valid until: _____. Unless otherwise specified, this Authorization is valid for 90 calendar days after the date of signing this form. After 90 days, the record copies will be destroyed. There will only be charges for third-party medical record requests. No refunds will be issued.

It is prohibited by law to release/disclose the attached/enclosed information to anyone except those specified above, I understand that this Authorization alone may not authorize release of psychiatric or HIV information.

Patient Signature: _____ Date: _____
 Witness Signature: _____ Date: _____

