

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

Medical Record Number:  
 Patient Name:  
 Birth Date:  
 SSN (Last Four Digits – Only):

I authorize UCLA / JACK H. SKIRBALL HEALTH CENTER to release PHI to:  
 (name of person/ facility which has information)

Name of person/ facility to receive PHI: \_\_\_\_\_

Hooiser Services Inc.

Address: 18032 Lemon Dr., #C-618

City, State & Zip Code: Yorba Linda, CA 92886 Fax:800.882.4156 / Phone:800.882.4156

email: service@hoosierserivcesinc.com

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 checked="" type="checkbox"/> Clinic <u>UCLA-EIMG CLINIC'S- Jack H.Skirball Health Center</u> (Specify Name of Clinic) |   |

Toluca Lake Health Center, Westside Health Center, Bob Hope Health Center & Santa Clarita

**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 & other Diagnostic Reports  |
| <input type="checkbox"/> EKG                              | <input type="checkbox"/> Radiology & other Diagnostic Images (x-rays, etc.) | <input type="checkbox"/> Consultations/Evaluations             |
| <input type="checkbox"/> Progress Notes                   | <input type="checkbox"/> Outpatient Clinic Records                          | <input type="checkbox"/> Genetic Testing Information           |
| <input type="checkbox"/> Drug & Alcohol Abuse Information |   | <input type="checkbox"/> Psychological/Vocational Test Results |
|   |   | <input type="checkbox"/> HIV/AIDS Test Results                 |
|   |   | <input type="checkbox"/> HIV/AIDS Treatment Information        |

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  
 Other (state reason) Insurance Purpose

Initials of Patient or Legal Representative: \_\_\_\_\_

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**NOTICE**

UCLA Health System 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) 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 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 System, 10833 Le Conte Avenue, CHS BH-225, 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**

\_\_\_\_\_  
 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/ Interpreter (only if patient unable to sign)

**UCLA HIMS, Release of Information**

Jack H. Skirball Health Center  
 23388 Mulholland Drive MS-22  
 Woodland Hills, CA 91364  
 Phone (818)876-1491 Fax (818)876-1446