

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

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

I authorize _____ to release PHI to:
(name of person/ facility which has information)

Name of person/ facility to **receive** PHI:
ANDREW F. LEUCHTER, M.D. / UCLA TMS PROGRAM - SEMEL INSTITUTE

Address: 760 WESTWOOD PLAZA, SUITE 57-467

City, State & Zip Code: LOS ANGELES, CA 90024

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 checked="" type="checkbox"/> Semel Neuropsychiatric Institute
<input type="checkbox"/> Home Health	<input type="checkbox"/> Jules Stein Eye Institute
<input type="checkbox"/> Clinic _____ (Specify Name of Clinic)	

TYPE OF RECORDS

<input checked="" type="checkbox"/> MEDICAL	<input checked="" type="checkbox"/> MENTAL HEALTH (other than psychotherapy notes)
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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 checked="" 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 checked="" type="checkbox"/> Consultations/Evaluations
<input checked="" type="checkbox"/> Progress Notes	<input checked="" 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
<input checked="" type="checkbox"/> Other : MEDICATION TREATMENT RECORDS		

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) _____

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
10833 Le Conte Ave, CHS BH225
Los Angeles, CA. 90095-78305
Fax: (310) 825-3356 Phone: (310) 825-6021