UCLA Ashe Center | Student Health and Wellness

STAFF USE ONLY: ☐ Completed by: _____

Authorization for Release of Medical/Billing Information

Patient Name (Last, First): ____
Birthdate:__________________ UCLA Student ID:_____________________________
Phone: ____________________ Email: ____

I authorize UCLA Ashe Center to release health information to:

Name: ____
Street Address: ____
City: ___________________________ State:______________ Zip: ___________
Phone:________________Fax: _________________ Email: ___________________

Type of Disclosure Request (choose one option):	
☐ Verbal Communication (ex. family member)	
☐ Paper Records	☐ Pick Up in Person ☐ Mail

Please specify the health information you authorize to release:

	All Dates	**OR Limited Dates**
☐ Immunization Records Only	☐	__ /__ /__ to __ /__ /__
☐ Laboratory Results Only	☐	__ /__ /__ to __ /__ /__
☐ X-ray Reports Only	☐	__ /__ /__ to __ /__ /__
☐ Optometry Records Only	☐	__ /__ /__ to __ /__ /__
☐ **All Medical Records**	☐	__ /__ /__ to __ /__ /__
☐ Itemized Billing Statements (incl. CPT codes)	☐	__ /__ /__ to __ /__ /__
☐ Statement of Medication Dispensed	☐	__ /__ /__ to __ /__ /__
☐ Other: ______________________________	☐	__ /__ /__ to __ /__ /__
Sensitive information will not be released unless specifically authorized below:		
☐ HIV/AIDS Test Results	☐	__ /__ /__ to __ /__ /__
☐ Drug/Alcohol Treatment Information	☐	__ /__ /__ to __ /__ /__
☐ Genetic Testing Information	☐	__ /__ /__ to __ /__ /__

Limitations upon disclosure: ____

The purpose of this release is: ☐ At the request of the patient ☐ Other (specify): ____________

You are entitled to receive a copy of this Authorization. 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. If not 90 days, the Authorization is valid until: _____________

____
Client/Patient/Patient Representative Signature

____ _______________
Relationship to Client/Patient (if other than Client/Patient) Date

Ashe Center Medical Records Office, 221 Westwood Plaza, Box 951703, Los Angeles, CA 90095-1703, Phone: 310-825-4694 Fax: 310-206-8012

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