UCLA **Arthur Ashe Student Health and Wellness Center**

MRN
Patient Name

(Patient Label)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information	Patient Name: _____ UCLA 9 digit ID: _____ Address: _____ City, State & Zip Code: _____ Date of Birth (MM/DD/YYYY): _____ Phone: (____) _____ E-Mail Address: _____
Specify Healthcare Facility	☐ UCLA Arthur Ashe Student Health and Wellness Center ("UCLA Ashe Center") ☐ U See LA Optometry ☐ Bruin Health Pharmacy
Release Records to *Where do you want records sent?* *Who do you want to receive the records?*	I authorize **UCLA Ashe Center** to release Health Information to: Name of Hospital/Clinic/Person: _____ Address: _____ City, State & Zip Code: _____ Phone: (____) _____ Fax: (____) _____ E-Mail Address: _____ If you would like a designee** to pick up your records, please fill out the following section: I authorize _____ to pick up copies of my medical record. Relationship to patient: _____ ****Note: Designee must provide valid photo ID**
Delivery Instructions *(please select one)*	☐ E-Mail ☐ Fax ☐ Mail ☐ Verbal ☐ In person (Call Requestor when records are ready for pick up) **I understand that if I choose delivery via fax or email, there are added security risks.** _____ **(*please initial)*
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☐ Other (state reason):

Health Information to be Released: *What records are being requested?*

Type of Records:

☐ **All Medical Records**	☐ Billing Statements	☐ Clinic Notes
☐ EKG only	☐ Immunization Records only	☐ Laboratory Reports only
☐ Optometry Images Only	☐ Optometry Records Only	☐ Radiology Reports (x-rays) only
☐ Statement of Medication Dispensed	☐ Other:	

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Sensitive Information	**Sensitive information <u>WILL NOT BE RELEASED</u> unless specifically authorized below:** **Initial next to each item that applies: _____ HIV/AIDS information _____ Drug/alcohol/substance abuse diagnosis/treatment _____ Genetic test results _____ Gender Affirming Care _____ Mental health (does not include CAPS records) _____ Psychiatric medication records _____ Reproductive Health (e.g. birth control pill, IUD, nexplanon, emergency contraception, pregnancy options counseling) _____ Abortion care-related records
Specify Date/Time Range of Records	■ SPECIFY DATE RANGE FOR RECORDS **<u>PRIOR TO JULY 8, 2025</u>:** FROM MM / DD / YYYY TO MM / DD / YYYY ■ **Records dated <u>ON OR AFTER JULY 8, 2025</u>, must be requested via UCLA Health:** https://www.uclahealth.org/patient-resources/medical-records
Expiration of Authorization	Unless otherwise revoked, this Authorization expires on _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing.
Signature(s)	_____ _____ (Signature of Patient / Legal Representative) Date _____ _____ Printed Name Area Code/Phone No. 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 Address
UCLA Ashe Center, Medical Records 221 Westwood Plaza Box 951703 Los Angeles, CA 90095-1703 Phone: 310-825-4694 Fax: 310-983-1172

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To protect our patients' confidential medical information, we must have a valid, complete and legible authorization to disclose their health information.

All sections of this authorization must be filled out before UCLA Ashe Center is permitted to disclose your protected health information.

Notice

UCLA Ashe Center and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Revocation

I may revoke this authorization at any time, provide that I do so in writing and submit it to:

Ashe Center Medical Records Office, 221 Westwood Plaza, Box 951703, Los Angeles, CA 90095-1703, Phone: 310-825-4694, Fax: 310-983-1172

The revocation will take effect when UCLA Ashe Center receives it, except to the extent that UCLA Ashe Center or others have already relied on it.

My Rights

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be made conditional on the signing of this authorization unless the authorization is for:

1) conducting research-related treatment,
2) obtaining information in connection with eligibility or enrollment in a health plan,
3) determining an entity's obligation to pay a claim, or
4) creating PHI to provide to a third party.

I am entitled to receive a copy of this Authorization,