U See LA Optometry- An Extension of the Ashe Center

Authorization for Release of Health Information

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

I authorize U See LA Optometry to release or exchange medical information to/with: (person or facility to receive health information)

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax:_____

Type of Disclosure:

☐ Verbal Information ☐ Copies of Records

Please specify the dates (s) of Optometry records you authorize to release:

☐ ____/ ____ / _____ to ____ / ____ / _____

☐ All dates

☐ Retinal images to be emailed to the following email:_____
Note: Retinal Images can only be emailed at this time.

Limitations upon disclosure: _____

The purpose of this release is:

☐ At the request of the client/patient/patient representative
☐ Other (state reason) _____

Notice: U See LA Optometry 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.

Your rights: This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility benefits may not be conditions on signing this Authorization except in the following cases: (1) to conduct 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) solely to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to:

308 Westwood Plaza, Ackerman Union B- Level Los Angeles, CA 90095
Phone: (310) 267-4772, Fax:(310) 267-1993

U See LA Optometry, 308 Westwood Plaza, Ackerman Union B-Level, Los Angeles, CA 90095

This revocation will take effect when U See LA Optometry receives it, except to the extent U See LA Optometry or others have already relied on it. You are entitled to receive a copy of this Authorization.

Unless otherwise revoked, this authorization is expires on _____. If no date is indicated, the Authorization will expire 12 months after the date of my signing this form. If not picked up within 7 days from the date of the request, records will be destroyed.

_____

Client/Patient/Patient Representative Signature

_____ _____

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