UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – SCOI

MRN:
Patient Name:

(Patient Label)

Patient Information	Patient Name: _____MRN: _____ Address: _____ City, State & Zip Code: _____ Date of Birth (MMDDYYYY): _____Phone: (____)_____
Specify Healthcare Facility	☐ SCOI Bakersfield Office ☐ SCOI Beverly Hills Office ☐ SCOI Porter Ranch Office ☐ SCOI Simi Valley Office ☐ SCOI Thousand Oaks Office ☐ SCOI Valencia Office ☐ SCOI Van Nuys Office
Release Records to *Where do you want records sent?* *Who do you want to receive records?*	I authorize **Southern California Orthopedic Institute** to release PHI 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 section below: I authorize _____ to pick up my medical record copies. Relationship to patient: _____ ***Note: Designee must provide valid photo ID**
Delivery Instructions *(please select one)*	☐ CD ☐ E-Mail (NPH/BHS does not release via email) ☐ Paper Copy ☐ Call Requestor when records are ready for pick up **Note:** If left blank, a CD will be provided.
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☐ Other (state reason) _____

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Health Information to be Released: *What records are being requested?*	**Type of Records**		
	☐ Medical Records	☐ Mental Health (other than psychotherapy notes)	
	☐ Billing Statements	☐ Emergency Reports (ER)	☐ Pathology Reports
	☐ Consultations	☐ History & Physical Exams	☐ Progress Notes
	☐ Discharge Summary	☐ Laboratory Reports	☐ Radiology Images (x-rays)
	☐ EEG Video	☐ Operative Reports	
	☐ EKG	☐ Other:	☐ Radiology Reports
Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results		
Specify Date/Time Period	SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE: FROM MM / DD / YYYY TO MM / DD / YYYY		
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 signed.		
Notification	By signing below, I understand that my health record is a shared record between Southern California Orthopedic Institute and UCLA Health.		
Signature(s)	_____ _____ (Signature of Patient / Legal Representative) Date _____ _____ Printed Name Area Code/Phone Number 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 Addresses	
☐ Please check box for medical records	☐ Please check box for radiology images
Southern California Orthopedic Institute 6815 Noble Avenue Van Nuys, CA 91405 moreino@scoi.com	**Image Management, Release of Information** Southern California Orthopedic Institute 6815 Noble Avenue Van Nuys, CA 91405

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COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

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

Notice

UCLA Health 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:

UCLA Health
Health Information Management Services
10833 Le Conte Avenue, CHS BH-902
Los Angeles, CA 90095-7305

The revocation will take effect when UCLA Health receives it, except to the extent that UCLA Health 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 conditioned on signing this authorization except if 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.