

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – SCOI

MRN:		
Patient Name		
	(Patient Label)	

Patient Information	Patient Name:MRN:			
IIIIOIIIIalioii	Address:			
	City, State & Zip Code:			
	Date of Birth (MMDDYYYY):Phone: ()			
Specify Healthcare Facility	 □ 5201 Truxtun Avenue, Bakersfield, CA 93309 □ 436 North Bedford Drive, Suite 202, Beverly Hills, CA 90210 □ Porter Ranch, 19950 Rinaldi Street, Suite 100, Northridge, CA 91326 □ 2655 1st Street, Suite 300, Simi Valley, CA 93065 □ 30870 Russell Ranch Road, Suite 330, Westlake Village, California 91362 □ 24051 Newhall Ranch Road, Building C, Valencia, CA 91354 □ 6815 Noble Avenue, Van Nuys, CA 91405 			
Release Records to	I authorize Southern California Orthopedic Institute to release PHI to:			
Where do	Name of Hospital/Clinic/Person:			
you want records	Address:			
sent?	City, State & Zip Code:			
	Phone: (FAX: ()			
	E-Mail Address:			
Who do you	If you would like a designee* to pick up your records, please fill out section below:			
want to	I authorize to pick up my medical record copies.			
records?	Relationship to patient:			
	*Note: Designee must provide valid photo ID			
Delivery Instructions	□ CD □ Paper Copy			
(please	□ Call Requestor when records are ready for pick up			
select <u>one</u>)	Note: If left blank, a CD will be provided.			
Purpose	☐ At the request of the patient/patient representative			
What is the purpose of this release?	☐ Other (state reason)			

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Health	Type of Records:					
Information to be	sychotherapy notes)					
Released:	□ Billing Statements	□ Eme	ergency Reports (ER)	☐ Pathology Reports		
What records	☐ Consultations	☐ Histo	ory & Physical Exams	☐ Progress Notes		
are being	☐ Discharge Summary	☐ Labo	oratory Reports	☐ Radiology Images		
requested?	☐ EEG Video	□ Ope	rative Reports	(x-rays)		
	□ EKG	□ Othe	er:	☐ Radiology Reports		
Sensitive Information	Sensitive information will not be released unless specifically authorized					
iniormation	below:					
	☐ Drug and Alcohol Abuse Results ☐ Constitution					
	☐ Genetic Testing Information☐ HIV/AIDS Test Results					
	☐ Psychological/Vocational Results					
Specify	SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE:					
Date/Time Period	FROM MM / DD / YYYY TO MM / DD / YYYY					
Expiration of	Unless otherwise revoked, this Authorization expires(insert					
Authorization	applicable date or event).					
	If no date is indicated this Authorization will expire 12 months after the date signed.					
	Decimals a balance I and decided that are the above I are the area of the second to a shape I are the second to a					
Notification	By signing below, I understand that my health record is a shared record between Southern California Orthopedic Institute and UCLA Health.					
Signature(s)		1		•••		
	(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					
	pationt		_			
	0: (10%)	••••				
	Signature of Witness (only if patient unable to sign) Output Date Interpreter ID #					
Mailing Addre	SSES			•		
T T						
			☐ Please check box for radiology images Image Management, Release of Information			
Southern California Orthopedic Institute 6815 Noble Avenue			Southern California Orthopedic Institute			
Van Nuys, CA			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.