

MRN:
Patient Name:
(Patient Label)

REQUEST BY PATIENT FOR ACCESS TO THEIR PROTECTED HEALTH INFORMATION (PHI)

NAME: _____

ADDRESS: _____

Phone Number: _____ Date of Birth: _____ Date: _____

- I would like to:
- access my PHI maintained by UCLA Health System. (By appointment ONLY)
 - obtain a **PAPER** copy of my PHI
 - obtain an **ELECTRONIC** copy (CD) of my PHI

The specific information I would like to access or receive a copy of is as follows:

<input type="checkbox"/> Entire Record		
<input type="checkbox"/> Audiology Reports	<input type="checkbox"/> EKG	<input type="checkbox"/> Outpatient Clinic Records
<input type="checkbox"/> Billing Statements	<input type="checkbox"/> Emergency Medicine Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Consultations	<input type="checkbox"/> History & Physical Exams	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Dental Records	<input type="checkbox"/> HIV/ AIDS Test Results	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Diagnostic Imaging Reports	<input type="checkbox"/> Laboratory Reports	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Reports	
Other _____		

I want to access my PHI that covers the following time period: _____

- Please notify me when the information is ready to be picked up at _____
- Please send the copies of my record to me at the above address
- Please send the copies of my record to me at the following address

Signature of Patient or representative _____ Date _____ Time _____

Relationship to patient (if representative): _____

When you have completed this form, please return it to:

**UCLA HIMS, Attn: Release of Information
 10833 Le Conte Ave, CHS BH225
 Los Angeles, CA. 90095-78305**

ROI Customer Service Phone: (310) 825-6021 Customer Service Fax: (310) 983-1458