UCLA Health

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:

☐ **Entire Record**		
☐ Audiology Reports	☐ EKG	☐ Outpatient Clinic Records
☐ Billing Statements	☐ Emergency Medicine Reports	☐ Pathology Reports
☐ Consultations	☐ History & Physical Exams	☐ Progress Notes
☐ Dental Records	☐ HIV/ AIDS Test Results	☐ Radiology Reports
☐ Diagnostic Imaging Reports	☐ Laboratory Reports	
☐ Discharge Summary	☐ 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