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**