

REQUEST BY PATIENT FOR ACCESS TO THEIR PROTECTED HEALTH INFORMATION

NAME: _____

ADDRESS: _____

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

- I would like to access my Protected Health Information maintained by UCLA Healthcare
 obtain a copy of my Protected Health Information

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

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

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

- Please notify me when the information is ready to be reviewed
- 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

Relationship to patient (if representative): _____

(Forward to the Privacy Management Office, UCLA Healthcare, 10833 Le Conte Avenue, Los Angeles, Ca 90095-7305)