AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PATIENT HEALTH RECORDS

I request and authorize the UCLA Oral Pathology Laboratory to release and disclose the patient UCLA Oral Pathology Laboratory records of ____as follows (please check options that apply):
[Patient Name]

Send a physical copy of the patient's oral pathology report and/or specimen or tissue microscopic slides by mail to the person/entity and address listed below. I am aware that shipping and/or replacement fees may be applied.

____
(Name)

____
(Street Address, City, State, Zip Code)

____

____
(Telephone/Contact Number)

NATURE OF THE INFORMATION TO BE RELEASED
I request and authorize the UCLA Oral Pathology Laboratory to release and disclose the following patient records (please check all that apply):

☐ Pathology Report(s) Accession/Lab(s) #:____

☐ Microscopic Slide(s) Accession/Lab(s) #:____

☐ Other: ____

SPECIFIC AUTHORIZATIONS
The following patient information will not be released unless you specifically authorize disclosure by checking the applicable box(es) below:

☐ specifically authorize the release and disclosure of information pertaining to drug and alcohol abuse, diagnosis, or treatment. (42 C.F.R. §§ 2.34 and 2.35).

☐ specifically authorize the release and disclosure of information pertaining to mental health diagnosis or treatment. (Welfare and Institutions Code §§ 5328, et seq.).

☐ specifically authorize the release and disclosure of HIV/AIDS test results. (Health and Safety Code § 120980 (g)).

☐ specifically authorize the release and disclosure of genetic testing information. (Health and Safety Code § 124980 (j)).

REVOCATION OF AUTHORIZATION
The UCLA Oral Pathology Laboratory usually will process a request for release and disclosure of patient records within 1-2 business days of receiving this authorization. You may revoke this authorization at any time ***before*** the above request has been processed by sending written notice to UCLA Oral Pathology Laboratory at oral_pathology@dentistry.ucla.edu or faxing your request to 310-206-4967.

The revocation will take effect upon receipt of your request by the UCLA Oral Pathology Laboratory, except to the extent that the UCLA Oral Pathology Laboratory has already relied on the authorization.

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this authorization will expire 12 months after the date of signing this form.

SIGNATURES

___________________________	___________________________		___________
Signature of Patient	Name of Patient		Date
___________________________	___________	___________________	________
Signature of Patient's Representative	Relationship	Name of Patient's Representative	Date

If signed by a Patient Representative, please check box in front of reason below.

☐ Patient is a minor. ☐ Patient is legally incompetent to sign. ☐ Patient is physically incapable of signing, but has given his/her verbal consent.
☐ Patient is unable to read English, but the Patient Screening Notice, Terms, and Consent was translated verbally for the patient, and the patient has given his/her verbal consent.

UCLA Oral Pathology return requests:____

Please return requested material promptly (if requested). Please note that any loss or damage to the requested specimen/tissue material after being released by UCLA Oral Pathology Laboratory may limit or prevent future adequate diagnostic use.