# HARBOR UCLA MEDICAL CENTER
# EMPLOYEE HEALTH SERVICES
# AUTHORIZATION
**To release Employee Health Medical Record Information**

**I hereby authorize the release of my medical record information to:**
**□ Myself □ Other/designee_____**
**Hospital I.D. will be required on request. Picture I.D. required at time of pick up by designee.**

**Date of request _____**

**Employee Name_____ Emp.#_____**

**SIGN FOR CONSENT_____**

**□ County Employee □ Morrison's □ Volunteer □ Pedus □ Other_____**
**□ Currently on staff □ Terminated (date)_____ □ Never hired**

**NOTE: Request will be ready in 7 days.** **Comment: _____**
**□ Fax requested: ( ) _____ (Note, faxed requests are not confidential.)**
**□ Request mailing information to: Address_____**
**City_____State_____Zip_____**

**Requests not picked up in 30 days will be mailed, if address label above is completed and a copy of your I.D. badge is attached to this request.**

**Employee Health Service staff accepting this request_____**
**□ Hospital I.D. copied & attached □ Driver's license copied & attached □ Label attached**

**The following information is requested:**