HARBOR - UCLA MEDICAL CENTER

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR PATIENTS IN POLICE CUSTODY

HEREBY AUTHORIZE THE HARBOR-UCLA MEDICAL CENTER TO RELEASE THE INFORMATION BELOW TO:

IAME OF POLICE DEPARTMENT/SHERIFF DEPARTMENT RESPONSIBLE FOR REFERRING PATIENT		
TATION NAME	STA. PHONE NO.	MCI NO.

PATIENT INFORMATION *(PLEASE PRINT):*

PATIENT NAME LAST	FIRST	M.I.	DATE OF BIRTH	SEX	RACE	
BOOKING NUMBER			FILE/URN NUMBER			

PURPOSE OF EXAMINATION:

VISIT/ADMIT/DATE	DISCHARGE DATE
VICTIM	**IN CUSTODY**
☐ SEXUAL ABUSE EVIDENCE COLLECTION	☐ BLOOD ALCOHOL WITHDRAWAL
☐ CHILD ABUSE	☐ PREBOOKING EXAM
☐ OTHER, SPECIFY: ______	☐ OTHER, SPECIFY: ______

PATIENT DESTINATION AFTER TREATMENT	
OFFICER'S NAME	OFFICER'S EMPLOYEE NUMBER
SIGNATURE OF OFFICER	DATE
SIGNATURE OF PATIENT	DATE
WITNESS SIGNATURE	DATE

DIAGNOSIS:

MEDICATION:

RECOMMENDATIONS:

CONDITION ON RELEASE:

Provider Printed Last Name:

Provider Signature: ID#:

Date: / / Time: : AM / PM

WHITE - FILE IN MEDICAL RECORD
CANARY - OFFICER'S RECORD
PINK - OUTPATIENT BILLING
GOLDENROD - PATIENT'S COPY