

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR PATIENTS IN POLICE CUSTODY

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

NAME OF POLICE DEPARTMENT/SHERIFF DEPARTMENT RESPONSIBLE FOR REFERRING PATIENT

STATION 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:

ADMIT/DATE	DISCHARGE DATE
------------	----------------

VICTIM

IN CUSTODY

- SEXUAL ABUSE EVIDENCE COLLECTION
- CHILD ABUSE
- OTHER, SPECIFY: _____

- BLOOD ALCOHOL WITHDRAWAL
- PREBOOKING EXAM
- 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:

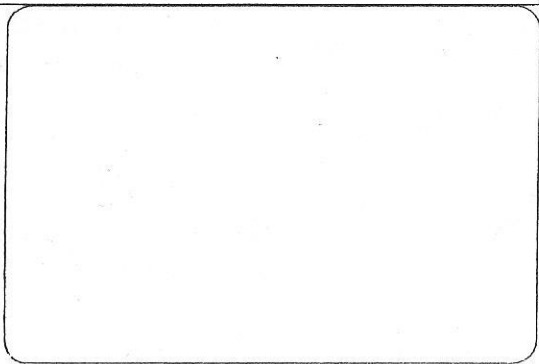
RECOMMENDATIONS:

CONDITION ON RELEASE:

Provider Printed Last Name: [Grid]

Provider Signature: [Grid] ID#: [Grid]

Date: [Grid] / [Grid] / [Grid] Time: [Grid] : [Grid] AM / PM



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