Olive View-UCLA
M E D I C A L   C E N T E R

Non-DHS Medical Records Request Form (OVMC Patients)

Requester's Information			
Requester's Name		Date & Time of Request	
Requester's Phone Number		Requester's Pager Number	
Requester's Email			
Provider Signature			
Reason for Request			

- Completing and submitting this form implies provider authorization to request records for patient care.

Patient's Information			
Patient's Name		Patient's DHS Medical Record Number	
Patient's Date of Birth		Patient's Date of Admission/Treatment Care	

Non-DHS Facility Information			
Name of Medical Facility		Contact Phone Number (if known)	
Location/Branch of Medical Facility (if applicable)			

Requested Medical Information
☐ H&P ☐ Operative Note(s) ☐ Radiology Images (specify): _____   ☐ Discharge Summary ☐ Behavioral Health Documentation ☐ Cardiology Results (specify): _____   ☐ Consult Notes ☐ Pathology Results (specify): _____   ☐ Lab Results (specify): _____

- **Send requests to:** ovroirequests@dhs.lacounty.gov
- **OVMC Release of Information hours of operation: Monday – Friday 8:00am – 4:30pm, excluding Holidays**
- **Follow off – hours process for requests outside of Release of Information staff availability**
- **Form should be used for medical records request from Inpatient floors and Emergency Department only**