

Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:			
Patient Name:	MRN (office use Only):	EMPI#(office use Only):	
Current Address	City	State	Zip
Phone Number ()	Date of Birth / /		
This authorization is to release the protected health information to:			
Name		Phone Number ()	
Address	City	State	Zip
Deliver by:	<input type="checkbox"/> In Person <input type="checkbox"/> Mail <input type="checkbox"/> By Phone <input type="checkbox"/> Fax Fax Number : <input type="checkbox"/> Secure Email Secure Email Address: <input type="checkbox"/> Secure Audio/Video Connection:		
This authorization is to release the protected health information from:			
Facility Name/Provider		Phone Number ()	
The purpose of this disclosure is:			
Dates of service requested:			
Release the following information:			
Patient Health Information:			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology report(s)	<input type="checkbox"/> Behavioral Health Admitting Evaluation	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology report(s)	<input type="checkbox"/> Behavioral Health Discharge Summary	
<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Lab report(s)	<input type="checkbox"/> Mental Health Therapy Records	
<input type="checkbox"/> Operative report(s)	<input type="checkbox"/> Cardiology report(s)	<input type="checkbox"/> Other records as specified	
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Treatment Plan(s)	<input type="checkbox"/> Emergency record(s)	
<input type="checkbox"/> Substance Use Disorder Treatment Record(s) _____			
Financial:			
<input type="checkbox"/> Itemized Billing Statement		<input type="checkbox"/> Financial Information	
This Authorization will remain in effect:			
<input type="checkbox"/> From the date of this Authorization or until the following event occurs: _____ Unless otherwise noted above this authorization will remain in effect 180 days from the date signed			

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to "this facility" to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Management/Medical Record Department. If I revoke this Authorization, Intermountain Healthcare may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility" treatment of me, enrollment in the health plan, or eligibility for benefits.
- Substance Use Disorder treatment records are protected by Federal Rule 42 CFR, part 2. Both a minor's and a parent guardian's signature must be obtained prior to disclosing the minor's Substance Abuse Disorder records.
- If I have questions about disclosure of my health information, I can contact the facility / clinic Medical Record Department, or call 844-442-1987.
- 我們將根據您的需求提供免費的口譯服務。請找尋工作人員協助;
- Si lo solicita, se le proveerá un servicio de interpretación gratis. Hable con un empleado del hospital para solicitarlo.
- If requested, we will provide you a free interpretation service. Talk to an employee of the hospital to apply.

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Signature of Patient or Personal Representative:	Date
If Signed by Personal Representative, Relationship:	Signature of Witness (optional)