

## **Authorization to Use and Disclose Protected Health Information**

Authorization to release the protected health information of:							
Patient Name:			MRN:		EM	IPI#	
Current		0		0	٦.		
Address		City		State	Zip		
Social Security Number -	-	Phone N	umber ( <u>)</u>			Date of Birth / /	
This authorization is to release the protected health information to:							
Name				Phone Number (	)		
Address		City		State	Zip		
This authorization is to release the protected health information from:							
Facility Name/Provider				Phone Number (	)		
				_			
Address	•	City		State	Zip		
The purpose of this disclosure is:							
Dates of service requested:							
Release the following information			_				
☐ Discharge Summary	☐ Pathology report(s)		☐ Iter	mized Billing S	tate	ment	
☐ History & Physical	☐ Radiology report(s)		☐ Psychiatric Admitting Evaluation			Evaluation	
☐ Consultation(s)	☐ Lab report(s)		☐ Psychiatric Discharge Summary			e Summary	
☐ Operative report(s)	☐ Cardiology report(s)		☐ Psychiatric testing				
☐ Progress notes	☐ Treatment Plan(s)		Other records as specified:			ecified:	
☐ Emergency record(s) ☐ Alcohol/Drug Treatment record(s)*							
This Authorization will remain in effect:							
☐ From the date of this Authorization until:							
☐ 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 <u>"this facility"</u> discloses my health information by my request, it cannot guarantee that the Recipient will not redisclose 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 <u>"this facility"</u> 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.

## To be used if facility requests this authorization:

I understand that:

- 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 <u>"this facility"</u> treatment of me, enrollment in the health plan, or eligibility for benefits.
- Chemical dependency 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 chemical dependency treatment
  records.

If I have questions about disclosure of my health information, I can contact the Health Information Management Medical Record Department

Signature of Patient or	Date
Legal Representative:	
If Signed by Legal	Signature of
Representative, Authority:	Witness (optional)

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