



### Authorization to Use and Disclose Protected Health Information

**Authorization to release the protected health information of:**

Patient Name:		MRN	EMPI #
Current Address		City	State Zip
Social Security Number	Phone Number ( )	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:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Pathology report(s)               | <input type="checkbox"/> Itemized Billing Statement       |
| <input type="checkbox"/> History & Physical  | <input type="checkbox"/> Radiology report(s)               | <input type="checkbox"/> Psychiatric Admitting Evaluation |
| <input type="checkbox"/> Consultation(s)     | <input type="checkbox"/> Lab report(s)                     | <input type="checkbox"/> Psychiatric Discharge Summary    |
| <input type="checkbox"/> Operative report(s) | <input type="checkbox"/> Cardiology report(s)              | <input type="checkbox"/> Psychiatric Testing              |
| <input type="checkbox"/> Progress notes      | <input type="checkbox"/> Treatment Plan(s)                 | <input type="checkbox"/> Other records as specified:      |
| <input type="checkbox"/> Emergency record(s) | <input type="checkbox"/> 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 "*this facility*" 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 "*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 or 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 "*this facility's*" treatment of me, enrollment in the health plan, or eligibility for benefits.
- I may make a request in writing at any time to "*this facility*" to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.

\*Alcohol/drug 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 alcohol/drug 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 Legal Representative	Date
If Signed by Legal Representative, Authority	Signature of Witness (optional)

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