PRIVACY–AUTHORIZATION TO USE & DISCLOSE PHI FORM CHECKLIST

Intermountain Healthcare Authorization to Use and Disclose Protected Health Information (PHI)

Authorization to release protected health information of:

- ☐ Patient's full name.
- ☐ Patient's address.
- ☐ Patient's Date of Birth (DOB).
- ☐ Patient's telephone number (preferred, not required).

This authorization is to release the protected health information to:

- ☐ Full name of person(s) or business to release protected health information to.
- ☐ Address.
- ☐ Telephone number (preferred, not required).
- ☐ Delivered by: This section is only used by HIM

This authorization is to release the protected health information from:

- ☐ This section can be pre-filled. Example: Intermountain Healthcare, 4646 Lake Park Blvd, SLC, UT 84120. Phone: 801.442.1600.
- ☐ If not pre-filled, the patient may specify "All my Healthcare Providers", "IHC", etc.
- ☐ **HBS/PFS/PB:** This authorization is **NOT** valid if it **ONLY** lists Intermountain's collection agency (e.g., IC System, CBE). It is valid if the collection agency is listed with Intermountain (e.g., Intermountain/CBE, IHC/IC Systems).
- ☐ Providers' phone number (preferred, not required).

The purpose of this disclosure is:

- ☐ This must be filled out to be considered HIPAA compliant.

Dates of Service requested:

- ☐ Dates of service are required.
  - This **CANNOT** be left blank.
  - It is acceptable if patient lists "Any dates" or "All dates".
  - If date(s) specified, Intermountain can ONLY disclose those specific dates of service.

Release the following information:

- ☐ Patient needs to specify what information can be released in order to validate the release.
  - There are two sections: One for "Patient Health Information" (records) and one for "Financial" (HBS/PFS/PB)

This authorization will remain in effect:

- ☐ Specific date or event.
  - Example: "Until further notice", "Death", "Claim settled".
- ☐ Unless otherwise noted, the authorization will remain in effect 180 days from the date signed.

Required Statements:

In order for a non-Intermountain Healthcare form to be valid it must contain wording similar to **ALL** of the following statements:

- ☐ 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 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.

Signature of Patient or Personal Representative
☐ Release has been signed and dated by patient. ☐ If the patient is an adult and the release has been signed by a personal representative, Intermountain needs supporting legal documentation. ☐ If a patient is a minor and the release has been signed by a guardian or personal representative, state their relationship to the patient (preferred, not required).
Validated Authorization to Use and Disclose PHI Form
Scan validated "Authorization to Use and Disclose PHI" to HELP2/iCentra. • HBS/PFS/PB: Note any effected encounter(s). • HIM will scan forms that contain either a future expiration date, a request for financial information or addressed to Intermountain Healthcare **Please Note: **ONLY** validated Forms should be scanned.