Intermountain Healthcare

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: ☐ In Person ☐ Mail ☐ By Phone ☐ Fax Fax Number : ☐ Secure Email Secure Email Address: ☐ 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:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Operative report(s)
- ☐ Progress notes
- ☐ Pathology report(s)
- ☐ Radiology report(s)
- ☐ Lab report(s)
- ☐ Cardiology report(s)
- ☐ Treatment Plan(s)
- ☐ Contact Information for non-emergent transportation services
- ☐ Behavioral Health Admitting Evaluation
- ☐ Behavioral Health Discharge Summary
- ☐ Mental Health Therapy Records
- ☐ Substance Use Disorder Treatment Record(s)
- ☐ Emergency record(s)
- ☐ Other Protected Health Information as specified _____

Financial:

- ☐ Itemized Billing Statement
- ☐ Financial Information

This Authorization will remain in effect:

- ☐ 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.

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

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