Intermountain Healthcare

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	
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 ☐ Fax Fax Number : ☐ Secure Email Secure Email Address:	

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)	☐ Itemized Billing Statement
☐ History & Physical	☐ Radiology report(s)	☐ Behavioral Health Admitting Evaluation
☐ Consultation(s)	☐ Lab report(s)	☐ Behavioral Health Discharge Summary
☐ Operative report(s)	☐ Cardiology report(s)	☐ Mental Health Therapy Records
☐ Progress notes	☐ Treatment Plan(s)	☐ Other records as specified:_____
☐ Emergency record(s)	☐ Substance Use Disorder 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 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 *"this facility"* treatment of me, enrollment in the health plan, or eligibility for benefits.
- Substance Abuse 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 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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