Intermountain Healthcare

RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Request to release health information of:

Patient Name:	MRN:	EMPI#
Current Address: City State Zip		
Social Security Number - -	Phone Number ( )	Date of Birth / /

This is to release health information to (if other than the patient)

- ☐ Personal Representative
- ☐ Hospital - Receiving Facility_____
- ☐ Physician/Office – Receiving Clinic_____
- ☐ Other; specify:_____

Name:

Address: City State Zip

The purpose of this disclosure is:

- ☐ Patient Request
- ☐ Treatment
- ☐ Payment purposes
- ☐ Other; specify:_____
  _____

Disclosure Method:

- ☐ Verbal
- ☐ Faxed to _____ Fax Number _____
- ☐ Copies
- ☐ DVD
- ☐ Secure Email Address _____
- ☐ Mail
- ☐ Other:_____

Dates of service:

Release the following information:

☐ Discharge Summary	☐ Emergency record(s)	☐ Mental Health Therapy record(s)
☐ History & Physical	☐ Pathology report (s)	☐ Treatment Plan(s)
☐ Consultation(s)	☐ Radiology report(s)	☐ Alcoholic/Drug Treatment record(s)
☐ Operative report(s)	☐ Lab report(s)	☐ Specific Visit Record(s)
☐ Progress notes	☐ Cardiology report(s)	☐ Other records as specified:

Verification:

- ☐ Photo ID#_____
- ☐ Return phone call to_____
- ☐ Other_____

Person releasing information (First & Last Name)	**Date:**
Releasing Facility: Department:	

* Alcohol/drug treatment records are protected by Federal rule 42 CFR, part 2.