Intermountain Health

Authorization to Disclose Protected Health Information to Community-Based Assistance Providers

Authorization to release the protected health information of: Patient Name:	MRN / EMPI# (office use only):
Current Address City State Zip	
Phone Number ( )	Date of Birth / /

You authorize Intermountain Healthcare and SelectHealth to share your relevant protected health information with community-based social services providers so they can assist you or connect you with other community providers that can assist you. Examples of community social service providers include organizations that help with food, transportation, shelter, utilities, etc.

Dates of service requested: ALL DATES

Release the following information: Patient demographics, contact information, and relevant health or other personal information needed to match you to appropriate services and determine service eligibility.

This Authorization will remain in effect from the date of this Authorization until all activities related to the patient's community services referral cases are completed.

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)

ROI 50318