UNIVERSITY OF UTAH HEALTH CARE

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name_____ **Medical Record #**_____

Date of Birth_____ **Phone # (** _____ **)**_____

Patient Address_____

_____

Patient E-Mail Address_____ **Soc. Sec. #**

_____ **(Providing your SS# is voluntary, but necessary to accurately identify your medical records, if your Medical Record Number is not provided.) Failure to provide this information will likely delay the processing of your request.**

Approximate Dates of Treatment: _____

Information to be Disclosed

I authorize the following health care provider(s) to DISCLOSE my patient information:

_____ _____

_____ _____

_____ _____

Please include the following (circle to indicate your selection):

Full Record (check record volume with Health Information Representative)

History and Physical	Psychological Evaluation	Discharge Summary	Emergency Records	Radiology and Lab Reports
Outpatient Clinical Records	Psychosocial History	Consultation Reports	Immunizations	Operative Report

Other: _____

Please provide records in the following format:

_____On Paper* _____CD Rom (provided by UUHSC) _____Thumb Drive (provided by UUHSC at cost)

_____ Email, list e-mail address if different than above:_____

***NOTE: There may be a cost if copies number more than 10 pages.**

Recipient Information

I authorize the following person(s) or organization TO RECEIVE my patient information:

a. **Name:**_____ **Relationship:** _____

Address: _____

_____ Phone # _____

b. **Name:**_____ **Relationship:** _____

Address: _____

_____ Phone # _____

RELEASE OF INFORMATION

Please indicate the purpose of the disclosure of your patient records:_____or Check here if it is for your own personal use _____.

If applicable, I understand that based on the dates, providers, and information I have designated above; the disclosure UUHSC makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that the University of Utah Health Sciences Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Medical Records, 50 North Medical Drive, SLC UT 84132

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one):

____1 year from the date below, _____One time disclosure only, _____Other: _____

I understand that I may be charged for this information, and I agree to be financially responsible for the charge.

_____

Signature of Patient or Representative Date

_____

If Applicable, Printed Name of Personal Representative

Description of Personal Representative Authority:

Parent _____ Medical Power of Attorney,_____(attach documentation) Other_____
(Explain and attach documentation)

Signature must be verified by UHC staff OR must be notarized. When complete, place in patient's medical record.

_____ _____ _____

Signature of UHC Staff Member Printed Employee's Name Date

NOTARY PUBLIC

Name: _____

SUBSCRIBED AND SWORN before me this_____day of_____, 20____.

Residing in _____ My Commission expires: _____