



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
Social Security Number - -	Phone Number ()	Date of Birth / /	
This authorization is to release the protected health information to:			
Name	Phone Number ()		
Address	City	State	Zip
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:			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology report(s)	<input type="checkbox"/> Itemized Billing Statement	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology report(s)	<input type="checkbox"/> Psychiatric Admitting Evaluation	
<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Lab report(s)	<input type="checkbox"/> Psychiatric Discharge Summary	
<input type="checkbox"/> Operative report(s)	<input type="checkbox"/> Cardiology report(s)	<input type="checkbox"/> Psychiatric Testing	
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Treatment Plan(s)	<input type="checkbox"/> Other records as specified: _____	
<input type="checkbox"/> Emergency record(s)	<input type="checkbox"/> Alcohol/Drug Treatment record(s)*	_____	
This Authorization will remain in effect:			
<input type="checkbox"/> From the date of this Authorization until: _____			
<input type="checkbox"/> 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 or 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's" treatment of me, enrollment in the health plan, or eligibility for benefits.
- I may make a request in writing at any time to "this facility" to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.

*Alcohol/drug 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 alcohol/drug treatment 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)