HEALTH
UNIVERSITY OF UTAH

PATIENT OPT-OUT OF PATIENT DIRECTORY

Patient Name _____ **Medical Record #** _____

Date of Birth _____ **Account #** _____

I understand that by choosing to opt-out of the patient directory, my name will not be published in the patient directory and therefore not available to those who call a UHC facility and ask for me by name. **This means that the UHC will be unable to transfer callers (including family, friends, or spouse) to my room or let callers know that I am in the hospital or at a clinic.**

I understand that this request does not apply to directory information provided prior to opting out.

I also understand that this request does not apply to clergy and that if I do not wish to be visited by clergy, I must let the registration clerk know.

_____ _____
Signature of Patient or Representative Date

_____
If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority:

☐ Parent ☐ Medical Power of Attorney

☐ Other, explain: _____
and attach documentation.

Signature must be verified by U of U Health staff or notarization may be required. When complete, place in patient's medical record.

- _____ _____ _____
  Signature of UHC Employee Printed Name and Employee ID# Date
- SUBSCRIBED AND SWORN before me this ____ day of _____, 20____.

NOTARY PUBLIC
Residing in _____

My Commission expires: _____

RELEASE OF INFORMATION