UNIVERSITY OF UTAH
HEALTH CARE

PATIENT AUTHORIZATION
TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ Medical Record # _____

Date of Birth _____ Phone # (_____)_____

Patient Address _____

(City) (State) (Zip)

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

Approximate Dates of Treatment: _____

1. I authorize the following health care provider or facility to DISCLOSE my patient information.

_____ University Hospital (Inpatient) _____ University Neuropsychiatric Institute (UNI)

_____ Moran Eye Center _____ University Orthopædics Center

_____ Huntsman Cancer Hospital _____ Huntsman Cancer Institute

_____ Community Clinic(s), Please identify clinic: _____

_____ Outpatient Clinic(s): _____

_____ Specific Provider(s): _____

_____ Other: _____

2. I authorize the following person or organization TO RECEIVE my patient information:

a. Name: _____ Relationship: _____

Address: _____

_____ Phone # _____

(City) (State) (Zip)

b. Name: _____ Relationship: _____

Address: _____

_____ Phone # _____

(City) (State) (Zip)

3. Please disclose the following informaton: (circle to indicate your selection)

History and Physical	Psychological Evaluation	Discharge Summary	Educational Report
Treatment Plans	Psychosocial History	Consultation Reports	Immunizations
E.R. Records	Outpatient Clinical Records	Radiology and Lab Reports	Operation Report

Other: _____

* RELEASE OF INFORMATION *

4. Please indicate the purpose of the disclosure of your patient records: _____

_____, or check here ____ if it is for your own personal use.

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

6. 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.

7. I understand that the University Health Care 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.

8. 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.

9. 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: _____
(up to 3 years)

10. 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, Name of Personal Representative

Representative's Authority: _____

☐ Parent ☐ Medical Power of Attorney

☐ Other, explain: _____
and attach documentation.

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

- _____ _____ _____
  Signature of UUHC Staff Member Printed Name and Employee ID# Date

- SUBSCRIBED AND SWORN before me this _____day of _____ , 20____ .

NOTARY PUBLIC

Residing in _____

My Commission expires: _____

UUHC Internal Use Only

☐ Staff Member processing Request's Name and Employee ID: _____

☐ Date Received: _____

☐ Date Sent to Patient _____

☐ A 30-day extension has been requested. Reason: _____

☐ Patient Notified of Extension On: _____

☐ Request Processed by (Name and Employee ID): _____

☐ Fee Charged (if any): _____