PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: (Please Print)		DOB:	MRN:
Patient Email:		Phone #:	SSN Last 4 Digits:
Patient Address:			
	City:	State:	Zip:
Approximate Dates of Treatment:			

Information to be Disclosed: I authorize the following health care provider(s) to DISCLOSE my patient information:
☐ University Hospital ☐ Huntsman Cancer Institute ☐ Neuropsychiatric Institute ☐ Other _____

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

Clinic/Office Visit Notes	History and Physical	Discharge Summary	Immunizations	Psychosocial History
Radiology/Lab Report	Consultation Report	Operative Report	Emergency Reports	Other: _____

Please provide records in the following format: (additional costs may apply for media formats and paper more than 10 pages)
☐ On Paper ☐ Thumb Drive (addl cost) ☐ CD ROM (addl cost) ☐ MyChart/Email

Recipient Information: I authorize the following person(s) or organization(s) to RECEIVE my patient information

1	Name:	Relationship:
	Phone:	Fax:
	Address:	
2	Name:	Relationship:
	Phone:	Fax:
	Address:	

- Please indicate the purpose of the disclosure of your records: _____ or check here for
  ☐ Personal Use ☐ Continuing Care ☐ Legal ☐ Disability
- If applicable, I understand that based on the dates, providers, and information I have designated above; the disclosure UUHC makes pursuant to this auth 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 N Medical Drive, Salt Lake City Utah, 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:
Printed name of Representative:	

Representative's Authority:
____ Parent ____ Medical Power of Attorney
____Other, explain: _____
Please attach documentation

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

Signature of UUHC Staff Member	UNID or Printed Name	Date:

Notary Public
Name: _____

SUBSCRIBED AND SWORN before me this ___ day of _____, 20____
Residing in: _____My Commission expires: _____