# PATIENT AUTHORIZATION
# FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Patient Name** ________________________________ **Medical Record #** __________________________

**Date of Birth** ________________________________ **Phone # (________)** ______________________

**Patient 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:** ____________________________________________________________

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

_______ University Hospital (Inpatient)
_______ Moran Eye Center
_______ Huntsman Cancer Hospital
_______ University Neuropsychiatric Institute (UNI)
_______ University Orthopædics Center
_______ Huntsman Cancer Institute
_______ Community Clinic(s): (Clinic name)________________________________________________
_______ Outpatient Clinic(s):______________________________________________________
_______ Specific Provider(s): _____________________________________________________
_______ Other: ___________________________________________________________________

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

a. Name: ____________________________________________ Relationship: ____________________

Address: ______________________________________________________________________

____________________________________________ Phone # ________________________

b. Name: ____________________________________________ Relationship: ____________________

Address: ______________________________________________________________________

____________________________________________ Phone # ________________________

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

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

Other: ______________________________________________________________________________

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 UUHSC 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 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.

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: ______________

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

| | **<u>Description of Personal Representative Authority</u>:** |
|---|---|
| ____________________________________________ | ____________________________________________ |
| Signature of Patient or Representative Date | Parent ______ |
| | Medical Power of Attorney, ______ (attach documentation) |
| ____________________________________________ | |
| If Applicable, Name of Personal Representative | 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 Name and Employee ID# | Date |

☐ SUBSCRIBED AND SWORN before me this ____ day of ________________, 20____.

NOTARY PUBLIC

Residing in ________________________________ My Commission expires: _____________________

**UUHSC Internal Use Only**

☐ Staff Member Processing Request's Name and Employee ID: ___________________________

☐ Date Received: ___________________________

☐ Date Sent to Patient: ___________________________

☐ A 30 day extension as been requested. Reason: ____________________________________________

☐ Patient Notified of Extension On: ____________________________________________

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

☐ Fee Charged (if any): __________________________