Authorization for Use and Disclosure of Protected Health Information (PHI)
FORM MUST BE COMPLETE

PHONE: 866-270-2311 FAX: 877-865-9738

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No.** ***(optional)*****:**
Requester's Name:	**Recipient's Name:**	
Requester's Address:	**Address 1:**	
	Address 2:	
	City:	**State:** **Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Email** ☐ **Electronic Media, if available (*****e.g.,*** **USB drive, CD/DVD)**

Email Address (If email checked above. Please print legibly):

Purpose of disclosure (Insurance, doctor visit, etc.):

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Admission form ☐ Dictation reports ☐ Clinical Test - Lab ☐ Clinical Test - Imaging ☐ Medication Sheets		☐ Operative Information ☐ Nursing Information ☐ ER Information ☐ Physician orders ☐ Progress notes		☐ All PHI in medical record ☐ IMAGES ONLY ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______________ (***Initial Required***)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

For children under 18 years of age: I have legal custody of this minor child _______ (please initial)

____

ID type (ex. Utah DL), ID number, and exp date **(required)**

ROI

LONE PEAK HOSPITAL
Authorization for Use and Disclosure of PHI
11925 South State Street, Draper, UT 84020

HCA SHARED SERVICES CENTER
525 METROPLEX DRIVE
NASHVILLE, TN 37211
Phone: 866-270-2311

FEE SHEET

HCA contracts with HealthPort to process requests for copies of medical records.

The following must be presented:

- A completed authorization (all sections of the authorization must be completed for records to be released)

What we will provide at no cost to you:

- Records to your physician for continuing care. Please specify on the authorization what records are to be sent. If records are needed immediately, the physician's office should fax in their request to 877-865-9738.

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party. If you desire records for this purpose or for your own personal use, the records will be mailed to you and you may then re-disclose them to the third party. If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

Please notify me if the cost of my records exceeds $___________

$0.25 per page + applicable tax and postage cost

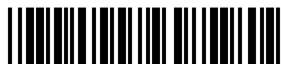
By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from ***HealthPort.***

PLEASE PRINT:

NAME:_________________________________ PHONE #: (   ) __________

ADDRESS:____
Street City State Zip

SIGNATURE:_________________________________ DATE:_____________



ROI

06/2013