MOUNTAINSTAR
Timpanogos
Regional Hospital

HCA SHARED SERVICES CENTER
525 METROPLEX DRIVE
NASHVILLE, TN 37211
TOLL FREE: 1-866-270-2311 FAX 1-877-865-9738

HCA contracts with 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. Pertinent information (an abstract) for continuing care includes transcribed reports (discharge summary, history and physical, operative reports), radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent, please specify on the authorization what records are to be sent.

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. 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.

.25 per page + applicable tax and postage cost

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

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:_______________

PARALLON BUSINESS SOLUTIONS℠

Nashville Health Information Management Service Center (HSC) - Release of Information
525 Metroplex Drive, Nashville Tennessee 37211
Phone: 615.695.8700 Toll Free: 1-866-270-2311 Fax 1-877-865-9738

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:** ☐ Home ☐ Cell ☐ Work	**Last 4 digit SSN (optional)**

Provider's Name: Timpanogos Regional Hospital	**Recipient's Name:**	
Provider's Address: 750 West 800 North Orem, UT 84057	**Recipient's Address 1:**	
	Recipient's Address 2:	**Recipient's Phone:**
	City:	**State:** **Zip:**

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

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

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

This authorization will expire ninety days from the date signed unless otherwise indicated below (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: (ex. doctor, insurance, personal, etc.)	**Date(s) of Service or Patient Account #**	

Description of information to be used or disclosed (You may check as many items below as you need)

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record		☐ Progress Notes		☐ ER information	
☐ Admission form (face-sheet)		☐ Physician Orders		☐ Labor/delivery summary	
☐ All Dictation reports		☐ Radiology Report		☐ OB nursing assess	
☐ Discharge Summary		☐ Lab Results		☐ Postpartum flow sheet	
☐ History and Physical		☐ Cath lab/EP lab		☐ Itemized bill:	
☐ Consultation		☐ Special test/therapy		☐ UB-04:	
☐ Operative Report		☐ Rhythm strips		☐ Other:	
☐ Emergency Room Report		☐ Nursing information		☐ Other:	
☐ Transfer Forms		☐ Medication sheets		☐ Other:	

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

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 re-disclosed.
5. I understand that I may see and obtain a copy 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:**

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

Print Name of Patient/Representative:	**Relationship to Patient:**	***Govt. Issued ID (include ID type, ID #, and exp. date)**

* Photocopy of ID must accompany this request

TIMPANOGOS REGIONAL HOSPITAL
Authorization for Use and Disclosure of PHI