MOUNTAINSTAR
Ogden Regional Medical Center
801-479-2061

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization form has been specifically designed to comply with all state and federal regulations pertaining to the confidentiality of health information. In order for this authorization to be considered valid, it must be completed in its entirety. Highlighted fields are required.

I AUTHORIZE OGDEN REGIONAL MEDICAL CENTER, 5475 SOUTH 500 EAST, OGDEN, UT 84405
TO RELEASE INFORMATION AND/OR COPIES OF MEDICAL RECORDS FOR THE FOLLOWING PATIENT:

PATIENT NAME: _____ DOB: _____

LAST 4 OF SSN#: _____ ADDRESS: _____

CITY/STATE/ZIP:_____ PHONE:_____

SPECIFIC INFORMATION TO BE RELEASED:

_____ BILLING STATEMENT	_____ E.R REPORT	_____ NURSING NOTES
_____ CATH LAB REPORT	_____ HISTORY & PHYSICAL	_____ OPERATIVE REPORT
_____ CONSULT REPORT	_____ LAB REPORT	_____ PATHOLOGY REPORT
_____ DISCHARGE SUMMARY	_____ LABOR/DELIVERY SUMM.	_____ PROGRESS NOTES/ORDER
_____ EKG/ECHO	_____ MEDICATION SHEETS	_____ SLEEP STUDY

_____ RADIOLOGY ☐ CT ☐ MRI ☐ PET ☐ ULTRASOUND ☐ XRAY _____ OTHER _____

DATE OF TREATMENT(S) (approximate if not known):_____

PURPOSE OF DISCLOSURE (appointment, insurance, personal, etc.)_____

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

RECORDS ARE TO BE RELEASED TO (WRITE "SELF", OR OTHER PERSON IF TO BE SENT TO ANOTHER INDIVIDUAL):

NAME: _____

ADDRESS: _____

Send via: Paper ☐ Electronic Media: CD ☐ USB ☐ Email ☐ _____
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.

This authorization is valid for 90 days from date of signing and may be revoked at any time by sending a written request to the Facility Privacy Officer prior to the expiration date. Revocation of this authorization shall not affect releases of information made prior to the revocation.
I understand that authorizing the disclosure of my Protected Health Information is VOLUNTARY and that I need not sign this authorization to assure medical treatment. I further understand that the disclosure of this information carries with it the potential for unauthorized redisclosure by the party released to and the information may no longer be protected by federal confidentiality rules.

PATIENT'S SIGNATURE: _____ DATE: _____ OR:
PARENT / GUARDIAN / PERSONAL REPRESENTATIVE (must provide a photocopy of supporting documentation)

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____PLEASE PRINT NAME: _____

GOVERNMENT ISSUED I.D. #: _____ VERIFIED BY: _____
Please mail completed form to 552 Metroplex Dr, Nashville, TN 37211 or fax to 1-877-865-9738. For questions, please call HealthPort at 1-866-270-2311