AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient's Full Name: _____ **Today's Date:** _____

Address: _____ **Date of Birth:** _____

City, State, ZIP Code: _____ **Telephone #:** _____

Please allow up to 10 business days for this request to be filled

1) I hereby authorize use of disclosure of protected health information regarding by care and treatment be released as set forth on this form.
2) I understand that this authorization may include disclosure of information to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and HIV-related information only if I place my initials on the appropriate lines below.
3) I specifically authorize release of information to the persons only indicated below. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal law.
4) Information disclosed under this authorization might be re-disclosed by the facility receiving it (except noted above in item 2) and would then no longer be protected by federal privacy regulations.
5) I understand that I have the right to revoke this authorization at any time in writing. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect these actions.
6) I understand that I have the right to request a list of people who may receive or use my information without authorization.

Name and address of health care entity to release my information:

Ortho Utah
990 Medical Dr #G-4
Brigham City, UT 84302
Office (435) 734-2151
Fax (435) 723-3391

_____
Physician Sign Off

Name and address of person(s) or entity to which my PHI will be released to:

_____

_____

_____

Specific Information to be released:

- ☐ Medical records from (insert date) _____ to (insert date) _____
- ☐ Entire medical record, including patient histories, office notes, (excluding psychotherapy notes), test results, radiology studies, referrals, consults, billing records, insurance records, and records sent to you by other health care providers
- ☐ Other: _____

Include: (Indicate by initialing)

_____ Alcohol/Drug treatment
_____ Mental health information
_____ HIV-related information

_____ *OR* _____

Signature of Patient

Signature of Guardian or Representative Authorized by Law