DEER HOLLOW

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)
1481 E Pioneer Rd Draper, UT 84020
801-679-6669

Staff, please send attention to: ____________

Patient Info

Patient name: ____________ Date of birth: ____________

Personal representative name: ____________ Phone number: ____________
(if applicable)

Recipient Info

For the above-named patient, Deer Hollow is authorized to:

☐ Release information to ☐ Obtain information from

Name of individual or organization to receive records: ____________

Address: ____________

Contact number: ____________ Fax number: ____________

Purpose

This release is for the purpose of:

☐ Continuity of Care ☐ Transfer of Care ☐ Insurance ☐ At the request of the Individual

☐ Disability ☐ School Entry ☐ Legal ☐ Other ____________

Release Method

How would you like your medical records released? ☐ Paper copy ☐ Electronic Copy

To whom? ☐ Patient to pick up ☐ Mail to patient ☐ Pick up by recipient ☐ Send to recipient

Note: Persons picking up records must provide a government-issued photo ID.

Medical Records/PHI Requested

By initialing below, I authorize the release of the following medical records:

Most recent 5-year medical record	____	Billing statements	____	Rehab Therapy	____
Laboratory reports	____	Mental health information	____		____
Chart notes	____	Genetic testing information	____	Other: ____________	____
	____		____		____
	____		____		____

Limitations

This authorization is limited to the following:

Provider(s)/Department(s): ____________

Time period: ____________ Worker's Compensation claim: ____________

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Expiration and Revocation	This authorization may be revoked at any time by giving written notice to Deer Hollow. The only exception is when action has been taken in reliance on the Authorization. If this Authorization has not been revoked, it will expire one year from the date of my signature unless a different expiration date or expiration event is stated. (Specify earlier expiration date or expiration event: ______________________.) To revoke this Authorization, please send a written statement to _________________________ (contact person) at ____ (address of person/entity disclosing information), and state that you are revoking this Authorization.
Understanding and Agreement	**My signature below indicates that I understand and agree to the following:** 1. *I understand that this is not a blanket authorization for the release of information.* 2. *I understand that treatment, payment, enrollment or, eligibility for benefits may not be conditioned on whether I sign this authorization and that I may refuse to sign the authorization.* 3. *I understand that I am entitled to a copy of this authorization, and I acknowledge that the recipient will receive a copy of this authorization.* 4. *I understand that there may be circumstances that would allow Deer Hollow Recovery & Wellness to receive compensation for the release of my records.* 5. *I understand that this authorization is intended for one-time only. I must re-execute it should additional requests for information occur.*
Signatures	Signature: ________________________ Date: ____________ Relationship to patient: ☐ Self ☐ Parent ☐ Personal Representative Description of Personal Representative's authority (if applicable): ________________________ Verification: ______________ Clerk: ______________ Date: ____________