



# DEER HOLLOW

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**  
PO Box 1078 Draper, UT, 84020  
801-839-7040

Staff, please send attention to:

<b>Patient Info</b>	Patient name: _____ Date of birth: _____ Personal representative name: _____ Phone number: _____ <small>(if applicable)</small>
<b>Recipient Info</b>	For the above-named patient, Deer Hollow is authorized to: <input type="checkbox"/> Release information to <input type="checkbox"/> Obtain information from  Name of individual or organization to receive records: _____ Address: _____ Contact number: _____ Fax number: _____
<b>Purpose</b>	This release is for the purpose of: <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the Individual <input type="checkbox"/> Disability <input type="checkbox"/> School Entry <input type="checkbox"/> Legal <input type="checkbox"/> Other _____
<b>Release Method</b>	How would you like your medical records released? <input type="checkbox"/> Paper copy <input type="checkbox"/> Electronic Copy To whom? <input type="checkbox"/> Patient to pick up <input type="checkbox"/> Mail to patient <input type="checkbox"/> Pick up by recipient <input type="checkbox"/> Send to recipient Note: Persons picking up records must provide a government-issued photo ID.
<b>Medical Records/PHI Requested</b>	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: _____
<b>Limitations</b>	This authorization is limited to the following: Provider(s)/Department(s): _____ Time period: _____ Worker's Compensation claim: _____

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<b>Expiration and Revocation</b>	<p>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 If this Authorization has not been revoked, it will expire one year from the date of my signature unless a different expiration date or expiration event is stated.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.</p>
<b>Understanding and Agreement</b>	<p align="center"><b>My signature below indicates that I understand and agree to the following:</b></p> <ol style="list-style-type: none"> <li>1. <i>I understand that this is not a blanket authorization for the release of information.</i></li> <li>2. <i>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.</i></li> <li>3. <i>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.</i></li> <li>4. <i>I understand that there may be circumstances that would allow Deer Hollow Recovery &amp; Wellness to receive compensation for the release of my records.</i></li> <li>5. <i>I understand that this authorization is intended for one-time only. I must re-execute it should additional requests for information occur.</i></li> </ol>
<b>Signatures</b>	<p>Signature: _____ Date: _____</p> <p>Relationship to patient:    <input type="checkbox"/> Self    <input type="checkbox"/> Parent    <input type="checkbox"/> Personal Representative</p> <p>Description of Personal Representative's authority (if applicable): _____</p> <p>Verification: _____ Clerk: _____ Date: _____</p>