PATIENT AUTHORIZATION
FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ **Medical Record#** _____

Date of Birth _____ **Phone#** (_____) _____ - _____

Patient Address _____

Soc. Sec. # ___ ___ ___ - ___ ___ - ___ ___ ___

(Providing your SS# is voluntary, but necessary to accurately identify your medical records, If your Medical Record Number is not provided.) Failure to provide this information will likely delay the processing of your request

Approximate Dates of Treatment: _____

1. **I authorize the following health care provider of facility to DISCLOSE my patient information:**

   _____**Central Valley Medical Center** _____**Nephi Medical Clinic**

   _____**Specific Provider(s):** _____

   _____**Other:** _____

2. **I authorize the following person(s) or organization TO RECEIVE my patient information:**

   a. **Name:** _____**Relationship:** _____

      Address: _____

      _____ **Phone#:** _____

   b. **Name:** _____**Relationship:** _____

      Address:_____

      _____ **Phone#:** _____

3. **Please disclose the following information: (circle to indicate your selection)**

History and Physical	Consultation Reports
Psychological Evaluation	Immunizations
Treatment Plans	Outpatient Clinical Records
Psychosocial History	Radiology and Lab Reports
Discharge Summary	Operative Report
Emergency Records	Other _____

4. Please indicate the purpose of the disclosure of your patient records:

_____

Or check here if it is for your own personal use._____

5. If applicable, I understand that based on the dates, providers, and information I have designated above; the disclosure Central Valley Medical Center makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

6. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

7. I understand that Central Valley Medical Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any Information used or disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to:
Medical Records, 48 West 1500 North, Nephi, UT 84648

9. I understand that my revocation is not effective to the extent that-action has been taken in reliance on this authorization. This authorization expires (check one):

___ 1 year from the date below ___ Onetime disclosure only __ Other: _____

10. I understand that I may be charged for this information, and I agree to be financially responsible for the charge.

Description of Personal Representative Authority:

_____ Parent___

Signature of Patient or Representative Date

Medical Power of Attorney,_____
(attach documentation).

_____ Other, explain:_____

If Applicable, name of Personal Representative and attach documentation.

CVMC Internal Use Only

- Staff Member Processing Request: Name and Employee ID_____
- Date Received: _____
- Date Sent to Patient: _____
- A 30-day extension has been requested.
  - Reason:_____
  - Patient Notified of Extension On:_____
- Request Processed by (Name and Employee ID): _____
- Fee Charged (if any):_____