



**AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Request Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ SS #: \_\_\_\_\_

**I authorize the use/disclosure of health information about me as described below:**

**I authorize:**

Blue Mountain Hospital                      802 South 200 West Blanding, UT 84511                      (435) 678-3993 (435) 678-3992  
 (person or facility)    (Address)    (Phone and Fax)

**To disclose information to:**

\_\_\_\_\_ (person or facility to disclose/use information)                      (Address)                      (Phone and Fax)

**DESCRIPTION OF INFORMATION TO BE DISCLOSED:**

Date of Admission/Treatment: \_\_\_\_\_

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Reports  | <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> Consultations   |
| <input type="checkbox"/> Pathology Reports  | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Procedure Reports    | <input type="checkbox"/> EKG Reports     |
| <input type="checkbox"/> Physical Therapy   | <input type="checkbox"/> Prenatal Records  | <input type="checkbox"/> Immunization Reports | <input type="checkbox"/> Emergency Dept. |
| <input type="checkbox"/> Others: _____      |  |   |  |

(Please Specify)

**Patient understands and accepts that these records may contain sensitive information on drug and/or alcohol, STD HIV testing/treatment/results.**

**The information will be used/disclosed for the following purposes:** \_\_\_\_\_

- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- If applicable, I understand that the person I am authorizing to use/disclose information will receive compensation for doing so.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

4. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization.

**COVID-19 (Corona Virus) Disclosure Authorization:**

1. I understand that there is a COVID-19 pandemic that may affect my healthcare and the care of others.
2. I understand and agree that to avoid a serious or imminent threat to the health and safety of a person or the public, I authorize Blue Mountain Hospital to disclose my health information to anyone who is in a position to prevent or lessen the serious and imminent threat, including family, friends, caregivers, law enforcement, public health organizations and disaster relief organizations without any additional authorization.
3. I understand and agree that my health information may include, among other things, my age and general health condition, whether I am a resident of the community or a visitor, whether I have a known contact with a COVID-19 positive patient, where I have traveled in the past 30 days, and, if I test positive for COVID-19, whether my providers believe it is community acquired.
4. I expressly defer to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health and safety.

**This authorization will remain in effect:**

- From the date of this Authorization until: \_\_\_\_\_
- Until the following event occurs: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

FOR HIM USE ONLY	Released by: _____	Released to: _____	Date: _____
	ID: _____		