BLUE MOUNTAIN HOSPITAL

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 Phone: (435)678-3993 Fax: (435)678-3992

To disclose information to:

_____

(person or facility to disclose/use information)

How to disclose information:

☐ Mailing address: _____

☐ Email: _____

☐ Fax: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

Date of Admission/Treatment: _____

☐ History & Physical	☐ Progress Reports	☐ Laboratory Reports	☐ Consultations
☐ Pathology Reports	☐ Radiology Reports	☐ Procedure Reports	☐ EKG Reports
☐ Physical Therapy	☐ Prenatal Reports	☐ Immunization Reports	☐ Emergency Dept.

☐ 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: _____

1. 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.
2. If applicable, I understand that the person I am authorizing to use/disclose information will receive compensation for doing so.
3. 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.
5. I understand that receiving records by email is not the most secure way to receive my records.

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: _____
