BLUE MOUNTAIN HOSPITAL

802 S 200 West
Suite A
Blanding, UT 84511
(435) 678-3993
info@bmhutah.org

Instructions for Completing
Authorization for Disclosure of Protected Health Information Form

1. Print legibly in **ALL** fields using black or blue ink.
2. Fill out the name or facility you want to RELEASE the patient information to. Be sure to include correct name/facility, address, email (remember email isn't always secure), phone and/or fax number, pick-up times depend on availability of a medical records clerk.
3. Date of Admission/Treatment is **REQUIRED**. Specify what date(s) of service to be released (e.g., April-May 2008, all dates of service, etc.).
4. Mark the appropriate boxed of which items are to be disclosed (e.g., labs, radiology reports, discharge summary, emergency dept.). If you would like all items for the date of service listed check "Others" and write in "All records".
5. "The information will be used/disclosed for the following purposes" – Please state why you want the information released (e.g., continued care, insurance claim, billing etc.).
6. This authorization will remain in effect – Indicate an expiration date for the release. Check the box to list a date or list an event (e.g., records are sent)
7. Signature required. If you are a personal representative for the patient you must state your relationship to the patient (e.g., legal guardian, power of attorney, etc.). **You will need to provide Identification** (passport, Driver's License, state or military ID) or proof of authority (power of attorney or proof of legal guardianship) is required to receive records.

FEES!!

Black & white copies – First 20 pages – free, additional pages will be $.20 a page
Color copies - $.40 a page
Radiology images on CD – $10.00

Fees can be paid by exact change, check, Credit or Debit Card

Refer to Utah Code 78B-5-618 regarding fees

ALL FIELDS MUST BE FILLED OUT IN ORDER TO PROCESS REQUESTS

Depending on the amount of information and medical significance, Medical Releases may take 1-5 business days but no longer than 30 days.

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:

☐ Pick up in person **see instructions*

☐ 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.
6. I understand that pickup time is dependent upon availability of the Medical Record Clerk.

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:_____
