**Authorization to Use and Disclose Protected Health Information**

*Please complete all sections of the form and attach required documentation to ensure timely processing*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Patient/Patient Representative)* , authorize **The Healing Sanctuary** to release protected health information (medical records) for the individual named below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Patient Date of Birth*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address Phone Number*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*City, State, Zip Code*

**The Purpose of this disclosure is:**

€ Medical Care or Consultation € Billing or Claims Payment € Personal Use € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date(s) of Service:** *from* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *thru* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released:** *(A copy fee of $1.00 per report will be charged if applicable)*

€ Lab Reports € Radiology Reports: Disc Images\_\_\_\_Reports\_\_\_\_ € EKG € Operative Report

€ Itemized Bills

€ Medical Record Abstract (Face sheet, History & Physical, Operative Report, Discharge Summary, Consultations, and Discharge Instructions)

I understand that if my medical or billing record contains information in reference to the conditions described below, **I must agree to the release by initialing on each applicable line:**

\_\_\_\_\_ HIV/AIDS testing or treatment

\_\_\_\_\_ Psychiatric treatment (excluding psychotherapy notes)

\_\_\_\_\_ Genetic testing records

\_\_\_\_\_ Sexually transmitted diseases

\_\_\_\_\_ Drug or Alcohol Abuse Records (diagnosis, treatment, or referral)

\_\_\_\_\_ Hepatitis B or C testing

**Information to be released to:**

€ Self - same as above information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Third Party receiving records Phone Number & Fax Number*

*Patient Label*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*City, State, Zip Code*

This authorization will expire in one (1) year unless an earlier date is specified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

I understand that I may revoke this authorization at any time by giving written notice to the Director of Health Information Management, 2325 Coronado St., Idaho Falls, ID 83404. I understand that revocation will not affect any action Mountain View Hospital took by relying on this authorization before they received my written notice.

I understand that this authorization to use or disclose protected health information is voluntary and Mountain View Hospital cannot deny or withhold health care services if I do not sign the authorization, except if the authorization is required for a research study in which I am enrolled, or if the service is solely for a third-party (pre-employment physical, etc.).

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient or Patient Representative Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Relationship of Patient Representative Description of Authority*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* **Records to be released via** € US Mail € Fax *Witnessed by/Employee* € Personal Pick-up € Emailed

**Form of ID or Proof Submitted:**

€ Driver’s License € Birth Certificate

€ Guardianship/Conservator Orders € Death Certificate

€ Durable Healthcare Power of Attorney € Signature Verification

€ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by Staff**

**Patient Identification or Proof of Authority to Authorize Release verified by:** \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

*Initials Date*

**Form of ID or Proof Submitted:**

€ Driver’s License / Photo ID € Birth Certificate

€ Guardianship/Conservator Orders € Death Certificate

€ Durable Healthcare Power of Attorney € Signature Verification

€ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN: \_\_\_\_\_\_\_\_\_\_\_ FIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Processed By: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

*Patient Label*

**Media:** € Paper Copies (including faxes) € CD/DVD

**Released via:** € US Mail € Fax € Personal Pick-up € Emailed