Uintah Basin Healthcare

(435)722-6169
(435)725-2084 fax

Authorization to Disclose Health Information

Patient Name: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

- ☐ Entire record
- ☐ History and physical
- ☐ Discharge summary
- ☐ Consultation reports
- ☐ Nursing notes
- ☐ Laboratory results
- ☐ X-ray and imaging reports
- ☐ Pathology:
- ☐ Other _____
- ☐ Clinic visit notes
- ☐ Immunization records
- ☐ Psychotherapy notes _____(initials)

From (date)_____ to (date)_____
From (date)_____ to (date)_____
☐ Blocks ☐ Slides ☐ Report

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. I request and authorize: _____to disclose this information for use to:
   _____
   Address: _____
   For the purpose of:_____
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company. Federal law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
   _____
   If I fail to specify an expiration event or condition, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have any questions about disclosure of my health information, I can contact UBMC 's Privacy Officer at (435) 722-4691 ext. 1377.

FOR UBMC USE ONLY

Medical Record # _____
ID: _____
# of Copies: _____
Amt. Billed: _____

_____ _____
Patient's Signature or Legal Representative Date

_____
Relationship to Patient ·

_____
Witness