

# Physician Group

OF UTAH, INC.

## Authorization for Use and Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_  
(Please print) (Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

I authorize \_\_\_\_\_ to disclose protected health information to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Purpose for use/disclosure: \_\_\_\_\_

Date(s) of service to be used/disclosed: \_\_\_\_\_

Information to be used/disclosed (check all that apply):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Entire Medical Record   | <input type="checkbox"/> Emergency Room Record      | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Consultation Report(s)  | <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Lab Reports       | <input type="checkbox"/> Pathology Report     |
| <input type="checkbox"/> Radiology Reports/Films | <input type="checkbox"/> Other _____                |  |   |

***\*Specific Authorization to Disclose Sensitive Records\****

**I understand that this authorization is to include use/disclosure of (please initial):**

\_\_\_\_\_ Alcohol and/or drug abuse records      \_\_\_\_\_ Psychiatric records  
\_\_\_\_\_ Sexually transmitted disease information      \_\_\_\_\_ HIV/AIDS information

\*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Physician Group of Utah has already relied on this authorization.
- I understand that I may revoke this authorization by mailing or faxing a written notice to the Regional Compliance and Privacy Officer, at Physician Group of Utah 406 W. South Jordan Parkway, South Jordan, Utah 84095 or fax to 801-984-3481, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is "none" unless otherwise specified here: Expiration: \_\_\_\_\_.
- I understand that Physician Group of Utah may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a "covered entity."

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Patient or Patient's Legal Representative)

Printed Name of Legal Representative: \_\_\_\_\_

Legal Representative's Authority to Act for Patient: \_\_\_\_\_

**PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.**