RELEASE OF INFORMATION AUTHORIZATION FORM

❑ Radiology Dept. ❑ Medical Records Dept.

- *All elements on the Authorization must be completed AND will require a current photo ID.*
- *This authorization is to be completed by the patient or patient representative (with legal documentation).*

Patient Name:	**Date of Birth:**	**Phone #:**

Address:	**City:**	**State:**	**Zip:**

TO RECIPIENT	❑ Self **or** ❑ Other (please indicate below)	**FROM FACILITY**	**ASHLEY REGIONAL MEDICAL CENTER** 150 WEST 100 NORTH VERNAL, UT 84078 Phone: (435) 789-3342 Med. Records Fax: (435) 789-6128 Radiology Fax: (435) 781-6884
	Name:		
	Address:		
	Phone: Fax:		

Date(s) of Service:

Select Specific Items or Basic Package:

❑ History and Physical
❑ Discharge Summary
❑ Consultation Report
❑ Operative Report
❑ Radiology Interpretation
❑ Radiology Imaging on CD
❑ Pathology Report
❑ Lab Results
❑ EKG Results
❑ Emergency Records
❑ Medication Records
❑ Psychotherapy Notes
❑ Physician Orders
❑ Other _____
❑ Other _____

❑ **BASIC PACKAGE** Includes:

History and Physical
Discharge Summary
Consultation Report
Operative Report
Radiology Interpretation
Pathology Report
Lab Results
EKG Results

❑ **I, the patient or the patient's representative, acknowledge that I have read the following statements:**

- Without a signed Authorization, I only have the right to view the information.
- Quality treatment or payment obligations continue even if I refuse to sign this Authorization.
- Once this information is disclosed (except to health plans or health care providers), it might be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Rule, as set forth in 45 C.F.R. 160 and 164.
- I understand that the persons hereby authorized to use/disclose **information** will not condition treatment or payment on my providing this authorization.
- I understand sensitive information, i.e. alcohol/substance abuse, HIV/AIDS, or mental health, may be included in the information being disclosed. I have the right to a copy of this authorization after signing.
- Except for previously disclosed information, this Authorization may be revoked by notifying the hospital in writing.
- This Authorization expires six (6) months from the date signed below **or** on _____/ _____ / _____.

Indicate the reason for this request:
❑ Personal ❑ Continuation of Care ❑ Insurance ❑ Legal Matters ❑ Other

Signature of Patient or Patient's Representative: **Date:** **Time:**

FOR OFFICE USE ONLY:

LICENSE #:	VERIFIED: ❑ YES SIGNATURE: ❑ YES	☐ FAXED ☐ MAILED ☐ PICKED UP	# PAGES:	MR #: ACCT #:
PICKED UP BY:	DATE:	TIME:		RELEASED BY:

(Revision 7/7/15)