MOAB REGIONAL HOSPITAL
450 W WILLIAMS WAY, MOAB UT 84532
PHONE: 435-719-3500 FAX 435-719-3719

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____ Date: _____

Address: _____ Phone: _____

**DESCRIPTION OF INFORMATION TO BE DISCLOSED**
**(This section must be filled out by patient or representative. Mark all that may apply.)**

Date of Admission: _____

| | | | |
|---|---|---|---|
| Discharge Summary _____ | Laboratory Reports _____ | History and Physical _____ | Consults _____ |
| Radiology Reports _____ | EKG Reports _____ | Operative Reports _____ | Pathology Reports _____ |

Other records (please specify) _____

*Patient understands and accepts that these records may contain sensitive information on drug and/or alcohol, STD, HIV information.*

The information will be used/disclosed for the following purposes: (This item is not required if the disclosure is requested by the patient unless disclosing substance abuse information.)

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 re-disclosed and no longer protected by these regulations.
2. If applicable, I understand that the person I am authorizing to use/disclose information for marketing purposes may 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. If the purpose of this authorization is for the use and/or disclosure of PHI for research study, and I refuse to sign this authorization, Moab Regional reserves the right to deny treatment associated with such research.
5. I understand that I may revoke this authorization in writing at any time by _____ except to the extent that action has been taken in reliance on this authorization. This authorization expires: _____.

**I hereby authorize _____ to disclose information described above**
**(Person or facility to disclose/use information)**

**to _____ who is _____**
**(Person or facility to receive information) (specify relationship to patient)**

**at phone #_____, fax #_____.**

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name (print)

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

***A copy of this signed form will be provided to the patient upon request.***

*Note: Medical Records fees for copies are:*
*10 pages or less, no charge*
*Over 10 pages, $.50 per page*