MOAB VALLEY HEALTHCARE, INC
450 W WILLIAMS WAY, MOAB UT 84532
PHONE: 435-719-3500 FAX 435-719-3719

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: (Please Print)	Date of Birth:	Phone:
Address:		

Entities Authorized to Use or Disclose Information: I hereby authorize Moab Valley Healthcare, Inc. ("MVH") and its affiliated hospital, clinics, and personnel to use or disclose the Patient's protected health information as described below.

Information to be Disclosed (check all that apply):
Information concerning my healthcare that was rendered between the following dates: _____/_____/_____ to _____/_____/_____.

☐ Discharge Summary ☐ Laboratory Reports ☐ History and Physical ☐ Consultation
☐ Radiology Reports ☐ EKG Report ☐ Operative Reports ☐ Pathology Reports
☐ Radiology Images ☐ Clinic Reports ☐ Other (please specify) _____
☐ Billing and payment records for healthcare rendered during the relevant time period.

Patient understands that the information to be disclosed may contain sensitive information concerning drug and/or alcohol use or treatment, sexually transmitted diseases ("STDs"), HIV, mental health or other sensitive health information.

Entity to Whom the Information Should Be Disclosed:

Name:	Fax:
Address:	

Purpose for Use or Disclosure:

☐ At My Request ☐ Legal ☐ Other (please specify) _____

☐ Marketing-MVH *will/will not* (circle one) receive remuneration from a third party for the use or disclosure of the information.

- I understand that I have the right to revoke this authorization at any time except to the extent that MVH or its affiliated personnel have has taken action in reliance on this authorization. To revoke this authorization, I must submit a written notice to: **Moab Valley Healthcare P.O. Box 998, Moab UT 84532**
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment unless (1) the purpose for the Patient's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.
- I understand that information described above may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.
- This authorization will expire on the following date or event: _____
  If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

If you have any questions about this Authorization, please contact the Health Information Management Department at 435-719-3706.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name (print)

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

A copy of this signed Authorization will be provided to the Patient or Personal Representative unless the Authorization was initiated at the request of the Patient or Personal Representative. .