MOAB REGIONAL HOSPITAL

PATIENT AUTHORIZATION FOR DISCLOSE OF PROTECTED HEALTH INFORMATION

Patient Name (please print):	Date of Birth:
Address:	
Email:	Phone:
Approximate Dates of Treatment:	

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):

☐ Discharge Summary ☐ Immunizations ☐ History and Physical ☐ Consultation Report
☐ Radiology/Lab Report ☐ EKG Report ☐ Operative/Emergency Report ☐ Pathology Report
☐ Radiology Images ☐ Clinic/Office Visit Notes ☐ Other (please specify) _____

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

Recipient Information:

Name of Person or Organization (please print):				
Address:				
Email:			Fax:	
Delivery Format and Fee:	☐ Pick-Up Paper Copies ($0.50/page if over 10 pages)	☐ Mail Paper Copies ($0.50/page if over 10 pages)	☐ Fax (no fee)	☐ Secure Email (no fee)

Purpose for Disclosure of Information

☐ Personal Use ☐ Legal ☐ Continuity of Care ☐Other (please specify) _____

- I understand that I have the right to revoke this authorization at any time except to the extent that MVH or its affiliated personnel 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, Utah 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 Personal Representative Date

_____ _____
Name of Signer (please print) Relationship of Signer 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.

FOR OFFICE USE ONLY:

Date Authorization Form Received:	Date Patient Received Records: