

JORDAN VALLEY MEDICAL CENTER
3580 West 9000 South, West Jordan, Utah 84088
Phone: 801-562-4227 Fax: 801-569-2157

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 Jordan Valley Medical Center to use or disclose protected health information to:

Name: _____ Phone/fax number: _____
Address: _____

Purpose for use/disclosure: _____

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

Information to be used / disclosed: _____ Entire Medical Record
_____ Emergency Room Record _____ Discharge summary
_____ History and Physical _____ Consultation report(s)
_____ Operative/procedure report _____ Lab reports
_____ Pathology report _____ Radiology reports/films
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 (42 CFR Part 2) prohibits 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 Jordan Valley Medical Center has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Regional Compliance and Privacy Officer, at Jordan Valley Medical Center, 3580 West 9000 South, West Jordan, Utah 84088 or fax (801) 964-3247, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which the authorization expires is: _____.
- I understand that Jordan Valley Medical Center 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 COMPETED IN ITS ENTIRETY, THANK YOU FOR YOUR COMPLIANCE.