



MOUNTAINSTAR

Mountain View Hospital

HCA SHARED SERVICES CENTER  
525 METROPLEX DRIVE  
NASHVILLE, TN 37211



HealthPort™

HCA contracts with HealthPort™ to process requests for copies of medical records.

**The following must be presented:**

- A completed authorization (all sections of the authorization must be completed for records to be released)

**What we will provide at no cost to you:**

- Records to your physician for continuing care. Pertinent information (an abstract) for continuing care includes transcribed reports (discharge summary, history and physical, operative reports), radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent, please specify on the authorization what records are to be sent.

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party. If you desire records for this purpose or for your own personal use, the records will be mailed to you. If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

Please notify me if the cost of my records exceeds \$ \_\_\_\_\_

**Cost: \$.25 per page + applicable tax and postage cost**

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from **HealthPort**.

PLEASE PRINT:

NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

<b>Section A: This section must be completed for all Authorizations</b>					
<b>Patient Name:</b>		<b>Birth Date:</b>	<b>Last 4 digits of SSN (optional):</b>		<b>Phone (xxx-xxx-xxxx):</b>
<b>Provider's Name:</b> Mountain View Hospital			<b>Recipient's Name:</b>		
<b>Provider's Address:</b> Attn: Medical Records ROI 1000 East 100 North Payson, UT 84651			<b>Address:</b>		
			<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Request Delivery (If left blank, a paper copy will be provided):</b> <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media, if available (e.g., USB drive, CD/DVD, Email) NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). Email address: _____					
This authorization will expire ninety days from the date of signature unless otherwise indicated below: (Fill in the Date or the Event but not both.)					
<b>Date:</b>			<b>Event:</b>		
<b>Purpose of disclosure:</b>					
<b>Description of information to be used or disclosed</b>					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Admission Form <input type="checkbox"/> Dictation Reports <input type="checkbox"/> Physician Orders <input type="checkbox"/> Intake/Outtake <input type="checkbox"/> Clinical Tests <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special Test/Therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer Forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/Delivery Summary <input type="checkbox"/> OB Nursing Assess <input type="checkbox"/> Postpartum Flow Sheet <input type="checkbox"/> Billing Record <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
<b>Section B:</b>					
<b>Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?</b>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial remuneration in exchange for using or disclosing this information?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, describe: _____					
May the recipient of the PHI further exchange the information for financial remuneration?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section C: Signatures</b>					
I have read the above and authorize the disclosure of the protected health information as stated.				<b>Date:</b>	
<b>Signature of Patient/Guardian/Patient Representative:</b>					
For children under 18 years of age: I have legal custody of this minor child _____ (please initial)					
<b>Print Name of Patient/Guardian/Patient Representative:</b>		<b>Relationship to Patient:</b>		<b>Govt. Issued ID (include ID type, ID#, and exp. date)</b>	

Encounter #: \_\_\_\_\_



## Release of Information

Local Phone: 801-465-7108  
Toll Free Phone: 1-866-270-2311  
Toll Free Fax: 1-877-865-9738