MountainStar
Ogden Regional Medical Center

# AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

***This authorization form has been specifically designed to comply with all state and federal regulations pertaining to the confidentiality of health information. In order for this authorization to be considered valid, it must be completed in its entirety. Highlighted fields are required.***

I AUTHORIZE OGDEN REGIONAL MEDICAL CENTER, 5475 SOUTH 500 EAST, OGDEN, UT 84405

TO RELEASE INFORMATION AND/OR COPIES OF MEDICAL RECORDS FOR THE FOLLOWING PATIENT:

PATIENT NAME: _____ DOB: _____

SSN#: _____ ADDRESS: _____

CITY/STATE/ZIP:_____ PHONE:_____

SPECIFIC INFORMATION TO BE RELEASED:

| | | |
|---|---|---|
| _____ BILLING STATEMENT | _____ E.R REPORT | _____ NURSING NOTES |
| _____ CATH LAB REPORT | _____ HISTORY & PHYSICAL | _____ OPERATIVE REPORT |
| _____ CONSULT REPORT | _____ LAB REPORT | _____ PATHOLOGY REPORT |
| _____ DISCHARGE SUMMARY | _____ LABOR/DELIVERY SUMM. | _____ PROGRESS NOTES/ORDER |
| _____ EKG/ECHO | _____ MEDICATION SHEETS | _____ SLEEP STUDY |
| _____ RADIOLOGY ☐ CT ☐ MRI ☐ PET ☐ ULTRASOUND ☐ XRAY | | _____ OTHER _____ |

DATE OF TREATMENT(S) (approximate if not known):_____

PURPOSE OF DISCLOSURE (appointment, insurance, personal, etc.)_____

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

**RECORDS ARE TO BE RELEASED TO** (WRITE "SELF", OR OTHER PERSON IF TO BE SENT TO ANOTHER INDIVIDUAL):

NAME: _____

ADDRESS: _____

This authorization is valid for 90 days from date of signing and may be revoked at any time by sending a written request to the Facility Privacy Officer prior to the expiration date. Revocation of this authorization shall not affect releases of information made prior to the revocation.

I understand that authorizing the disclosure of my Protected Health Information is VOLUNTARY and that I need not sign this authorization to assure medical treatment. I further understand that the disclosure of this information carries with it the potential for unauthorized redisclosure by the party released to and the information may no longer be protected by federal confidentiality rules.

PATIENT'S SIGNATURE: _____ DATE: _____ OR:

PARENT / GUARDIAN / PERSONAL REPRESENTATIVE (must provide a photocopy of supporting documentation)

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____PLEASE PRINT NAME: _____

GOVERNMENT ISSUED I.D. #: _____ VERIFIED BY: _____

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# FEE SHEET

HealthPort

Ogden Regional Medical Center 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. Please specify on the authorization what records are to be sent. If records are needed immediately, the physician's office should fax in their request to 877-865-9738.

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 and you may then re-disclose them to the third party. 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 $_____

**$0.25 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:_____