MOUNTAINSTAR
St. Mark's Hospital
1200 East 3900 South, Salt Lake City, UT 84124

Authorization for Use and Disclosure of Protected Health Information (PHI)

Section A: This section must be completed for all authorizations

Patient Legal Name:	**Birth Date:**	**Driver's License Number**
Address 1:		**Telephone No.**
City:	**State:**	**Zip:**

Section B: I hereby authorize St. Mark's Hospital to release my records to me at the address above OR to those designated below:

Name/Title _____

Address _____

Section C: This authorization will expire on the following: Date: OR Event:

_____

Section D: Purpose of request for records:

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media please specify type of media** _____ **if available (*e.g.*, USB drive, 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).**

Section E: Selected Portions of record

Date(s) of service(s): _____

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

☐ Abstract (summary of visit)
☐ History and physical report
☐ Discharge summary report

☐ Operation/surgery report
☐ Emergency room report
☐ Consult report
☐ Lab results
☐ Pathology report
☐ X-ray reports
☐ X-ray/MRI/CT images on disc
☐ Cardiac studies (EKG, echocardiogram, Cardiac catheterization, etc.)
☐ Cardiac study images on disc

☐ Progress notes
☐ Physician orders
☐ Anesthesia record
☐ Entire record
☐ Other: View record
☐ Other:

Section F:

_____ (Initial) **I acknowledge, and hereby consent to such, that the released information may contain genetic information, alcohol/drug abuse, psychiatric, HIV testing, HIV results or AIDS information.**

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 effect 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 re disclosed.
5. I understand that I may see and obtain a copy 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.

Section G: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**	**Relationship to Patient:**

Section H: Minor Patient: By initialing I verify that I am a custodial parent of the minor child _____ (Initial)

HCA SHARED SERVICES CENTER
525 METROPLEX DRIVE
NASHVILLE, TN 37211

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 $_____

.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:_____

8/12/2013