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| --- | --- | --- |
| **FOR OFFICE USE:** | **INDIVIDUAL** | **DATE** |
| **Request received by:** |  |  |
| **Request filled by:** |  |  |

**GUNNISON VALLEY HOSPITAL**

**P.O. Box 759**

**Gunnison, UT 84634**

**Phone: (435) 528-7246 Fax: (435) 528-2191**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize use or disclosure of the named individual’s health information as described below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Name | Date of Birth | | Medical Record # | | Social Security # |
| Address (Street, City, State, ZIP Code) | | | Telephone Number | | |
| The following individual or organization is authorized to make the disclosure:  🞎 GUNNISON VALLEY HOSPITAL  🞎 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| This information may be disclosed to and used by the following individual or organization:  🞎 GUNNISON VALLEY HOSPITAL  🞎 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Treatment Dates: | Purpose of Request: | | | | |
| The following information is to be disclosed: (please check) | | | | | |
| **Yes** **No**  🞎 🞎 ……...Discharge summary  🞎 🞎………History and physical examination  🞎 🞎………Consultations (including psych evaluations)  🞎 🞎………Operative report or procedure reports  🞎 🞎………Emergency Department record  🞎 🞎………Laboratory reports (including drug screens) | | **Yes** **No**  🞎 🞎………Radiology or imaging reports  🞎 🞎………Cardiac studies  🞎 🞎………Interdisciplinary records (progress notes)  🞎 🞎………Medication records  🞎 🞎……....Nursing notes  🞎 🞎………Physician orders  🞎 🞎……....Complete record | | | |
| 🞎 🞎……....Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. | | | | | |
| **Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization. | | | | | |
| **Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If I do not specify an expiration date, event, or condition, this authorization will expire in six months. | | | | | |
| **Redisclosure:** I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules. | | | | | |
| **Other Rights:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.  I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.  If I have any questions about disclosure of my health information, I can contact the Medical Records Department at 435-528-2128. | | | | | |
| Signature of Patient or Legal Representative | | | | Date | |
| If Signed by Legal Representative, Relationship to Patient | | | | | |

***Gunnison Valley Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.***

***Hospital del Valle de Gunnison cumple con las leyes federales de derechos civiles y no discrimina por raza, color, origen nacional, e dad, discapacidad o sexo.***

**Gunnison Valley Hospital tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.**