

# DAVIS HOSPITAL & MEDICAL CENTER

ID Verified By: \_\_\_\_\_

1600 WEST ANTELOPE DRIVE LAYTON, UTAH 84041

PHONE: (801) 807-7065 • FAX: (801) 807-7125

NAME OF PATIENT:		SOCIAL SECURITY NUMBER:	ADDRESS OF PATIENT:
			Street _____
TELEPHONE NUMBER:	Birthdate:	Age:	City _____
( )			State _____ Zip _____

**AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:**

F R O M	Name of Organization or Person Authorized to <b>RELEASE</b> information:
	_____ Phone/Fax: _____ Street _____ City _____ State _____ Zip _____
T O	Name of Organization or Person to <b>RECEIVE</b> information:
	_____ Phone/Fax: _____ Street _____ City _____ State _____ Zip _____

**Purpose of disclosure:** \_\_\_\_\_

I understand that I may revoke this authorization, in writing, at any time except to the extent that Davis Hospital and Medical Center has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to Dave Mason, at Davis Hospital & Medical Center, 1600 W Antelope Drive Layton, Utah 84041 or fax 801-807-7125, stating my intent to revoke this authorization.

I understand that Davis Hospital & Medical Center may not refuse treatment if this form is not signed.

I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Law, if the recipient is not a "covered entity".

Unless otherwise revoked, I understand that this authorization will expire in 60 days or on the specific date or event: \_\_\_\_\_

**INFORMATION TO BE RELEASED**

Beginning Date:	Ending Date
<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Emergency Room Report
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-ray Reports (Specify type or all): _____
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Laboratory Report (Specify type or all): _____
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Pathology Report	

**\*Specific Authorization to Disclose Sensitive Records\***

I understand that this authorization is to include 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) prohibit 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.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Signature of Other Authorized Person)

\_\_\_\_\_  
(Relationship to Patient)

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, or if no personal representative, the spouse or adult child of a deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and legal guardian. Emancipated minors may sign for self.

*Authorization to Release Protected Medical Information*