

# STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

After Hours Medical P.O. Box 1000 Draper, UT 84020 Phone: (801)260-1919 Fax: (801) 260-1441

## Patient Information

Name: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

Patient date of birth: \_\_\_\_\_

Patient SS#: \_\_\_\_\_

## Persons Authorized to Use or Disclose information

\_\_\_\_\_  
Name of person or organization

## Persons to Whom Information May Be Disclosed

\_\_\_\_\_  
Name of person or organization

Fax Records: Fax # \_\_\_\_\_

Mail Records: \_\_\_\_\_

## Purpose of Disclosure

\_\_\_\_\_  
["At the request of the individual" when individual initiates authorization and does not provide purpose]

## Information to be Used or Disclosed (check all that apply)

Physician's progress notes

Consultation reports and correspondence from other facilities

Laboratory test results

X-ray test results

X-ray films

Billing account history

Other: \_\_\_\_\_

Date(s) of Service

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Expiration Date of Authorization

This authorization is effective for six months unless revoked or terminated by the patient or the patient's personal representative.

## Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to After Hours Medical, P.O. Box 1000 Draper, UT 84020. You should contact the Privacy Officer to terminate this authorization. The Authorization may not be revoked if the Clinic has already taken action in reliance on your Authorization.

## Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**Your refusal to sign this authorization will not affect your ability to obtain treatment, payment or eligibility for health care benefits. I understand my records may include information pertaining to psychiatric issues, alcohol and/or drug abuse treatment and/or HIV status.**

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date