OGDEN**CLINIC**

ROI / HIPAA

Release Authorization for Protected Health Information

Name of Patient: ______________________________ ☐ **Ogden Clinic Employee**

Address: ______________________ City: ____________ State: ____ Zip: ______

Phone #: ______________ Social Security #: ______________ Birth date: ____________

Relationship to Patient if not self: ______________________________

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment from alcohol and drug abuse. I hereby consent to the release of this information. This information may be disclosed to and used by the following individual or organization: INITIAL _______

*****Alcohol/drug treatment records are protected by Federal Rule 42 CFR, part 2.**

Release my information to the following:

FacilityName/Provider/Other______________________Phone:____________Fax:__________

Address______________________City______________State_____Zip__________

If leaving the Clinic please indicate reason for request: (required)

- ☐ Moving
- ☐ Change Physician
- ☐ Insurance Change
- ☐ Dissatisfied__________________
- ☐ Other__________________

MEDICAL DATA/INFORMATION REQUESTED (please check)

- ☐ Most Current Visit with Lab & X-Ray
- ☐ Immunizations
- ☐ 2 year medical history
- ☐ 5 Year Medical History
- ☐ Whole Chart
- ☐ Pathology Reports
- ☐ EKG Reports
- ☐ Insurance Billing Data
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Other*(DATE NEEDED)__________

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Ogden Clinic's Privacy Officer at 1491 East Ridgeline Drive, South Ogden, Utah 84405. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

This authorization shall be in force and effect until______________________(Unless otherwise noted this authorization will remain in effect 180 days from the date signed)

Authorization Required Below

Signature		Date
Relationship to Patient	Witness to Signature	ID Checked

GENERAL POLICIES:

- ✓ A valid authorization signed by all patients over 18 years of age or by their legal guardian is REQUIRED BEFORE making any release of information, including copies.
- ✓ The release form must be COMPLETE (including zip codes and phone numbers) to ensure timely process.
- ✓ Specific authorization is required for all sensitive information.
- ✓ Please allow **10-14** business days to process requests. All record requests will be sent by mail.
- ✓ Copies of medical records being sent DIRECTLY to the healthcare provider or medical facility will not be charged.

FEE INFORMATION:

YOU WILL RECEIVE A BILL FROM HEALTHPORT ALONG WITH YOUR RECORDS.

There is a processing fee of .50 per page and shipping and handling if applicable.

Created by: HIPAA Privacy Sub-committee
Approval:
Created on 1/13/03 10:40 AM
Revisions Date: 01/06/2011dparker
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