



Authorization to Disclose Protected Health Information

Patient: _____ Date of Birth: _____

Address: _____

Telephone: _____

Other names under which the patient has been treated: _____

I REQUEST and GIVE PERMISSION FOR Star Valley Health to disclose my records to:

Address City State Zip Code Phone
Disclose records via (circle one): Email _____ Fax _____ disc pick up mail

MY MEDICAL RECORDS/INFORMATION for care provided between (date) _____ and (date) _____

INFORMATION TO BE RELEASED: (check all that apply)

- ___ Clinic Records ___ History and Physical Exam ___ Laboratory Report ___ Radiology Report
___ Radiology Images ___ Operative/Consultation reports ___ Discharge Summary ___ Billing records
___ Other _____

FOR THE PURPOSE OF: (check one)

- ___ Patients request ___ Changing physician ___ Continuation of care
___ For potential pending legal proceeding ___ other: _____

Sensitive Nature Records: The individual signing this authorization expressly authorizes Star Valley Health to disclose information regarding drug, alcohol, or substance abuse, HIV/AIDS, sexually transmitted diseases, communicable diseases, behavioral health, (excluding psychotherapy) and genetic marker 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) I understand that information disclosed by Star Valley Health pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations. 5) I understand that I may see and obtain a copy of the information described on this consent, for a reasonable copy fee, if I ask for it, and 6) I can get a copy of this form after I sign it.

This request will expire one (1) year from date of this release.

Date Patient or patient's representative signature Print Patient or patients Representatives' name