



PATIENT AUTHORIZATION
FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Medical Record # _____

Date of Birth _____ Phone # (_____) _____

Patient Address _____

Soc. Sec. # _____ (Providing your SS# is voluntary, but necessary to accurately identify your medical records, if your Medical Record Number is not provided.) Failure to provide this information will likely delay the processing of your request.

Approximate Dates of Treatment: _____

- 1. I authorize the following health care provider or facility to DISCLOSE my patient information:
University Hospital (Inpatient)
Moran Eye Center
Huntsman Cancer Hospital
Community Clinic(s): (Clinic name)
Outpatient Clinic(s):
Specific Provider(s):
Other:

- 2. I authorize the following person(s) or organization TO RECEIVE my patient information:
a. Name: Relationship:
Address:
Phone #
b. Name: Relationship:
Address:
Phone #

- 3. Please disclose the following information: (circle to indicate your selection)
History and Physical Treatment Plans
Psychological Evaluation
Psychosocial History
Outpatient Clinical Records
Discharge Summary
Consultation Reports
Radiology and Lab Reports
Emergency Records
Immunizations
Operative Report

Other: _____



