Incoming Records Authorization for Protected Health Information

Name of Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Social Security #: _____ Birth date: _____

Relationship to Patient (Circle Which Applies): Self / Parent / Legal Guardian

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 and mental health services and treatment for alcohol and/or 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.

I hereby authorize (If all information is not provided it may result in a delay/inability to obtain records.):

FacilityName/Provider/Other:_____

Address_____City_____State_____Zip_____

Phone_____Fax_____

To Release:

MEDICAL DATA/INFORMATION

- ☐ Most Current Visit with Lab & X-Ray
- ☐ Immunizations
- ☐ 6 Month Medical History
- ☐ 1 Year Medical History
- ☐ 2 Year Medical history
- ☐ 5 Year Medical History
- ☐ Pathology Reports
- ☐ EKG Reports
- ☐ Insurance Billing Data
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Other*_____ _____ (Date Needed)

To: (Provider Name) _____

☐ Ogden Clinic Medical Records
4650 Harrison Blvd
Ogden, UT 84403
Fax: (801) 475-3454
Phone: (801) 475-3000

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 4650 Harrison Blvd, Ogden, Utah 84403. 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.

Authorization Required Below

Signature of Patient or Legal Guardian:_____ Date:_____

Created by: HIPAA Privacy Sub-committee
Approval: Forms Committee
Revisions Date: 10/12/2013AW 05/28/15 MH
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