Authorization for Release of Protected Health Information (PHI)

Patient Name:
Date of Birth:
Address:
Telephone Number:
Medical Record Number:

I hereby authorize Intermountain Heart Center to disclose the above-named individuals' health information.

Description of Information to be released: (check all that apply)

- ☒ All medical information
- ☐ Progress notes
- ☐ Consultations
- ☐ Most recent history and physical
- ☐ Medication information
- ☐ Other_____
- ☐ Appointment information/Appointment history
- ☐ Laboratory reports
- ☐ Radiology/Imaging reports
- ☐ Radiology films
- ☐ Two-way verbal exchange of communication
- ☐ Financial/Billing information

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Name of Individual or Facility receiving information
Intermountain Heart Center

Address
5292 S College Drive, Suite 201 Murray, Utah 84123

Telephone number
801-281-4278

Fax number
801-281-5960

Website
IMHeart.com

Description of the purpose of the use and/or disclosure:

- ☒ Continuing Care
- ☐ Second Opinion
- ☐ Social Security/Disability (provide copy of SSA
- ☐ Letter) Consultation
- ☐ Insurance
- ☐ Financial Arrangement
- ☐ Legal purposes
- ☐ Personal Use
- ☐ Other: Please describe:_____
- ☐ Marketing - If this request is for marketing purposes, Intermountain Heart Center may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information (PHI).

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy regulations. Intermountain Heart Center may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Intermountain Heart Center. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative **Date:**

Printed name of Patient or Patient's Representative