Davis HealthSystem

**Authorization for Disclosure of Health Information**

(1) I hereby authorize _____ to disclose the following information from the health record (s) of:
Patient Name: _____ Date of Birth_____

Patient Telephone Number : _____ Visit ID/Patient MRN_____

Address: _____
(City) (State) (Zip Code)

Covering the period(s) of healthcare: **From (date)** _____ **To (date)** _____

(2) Mark an (X) next to the information to be disclosed: ____Complete Health Record(s) ___ X-Ray Images
Or only:____ Discharge Summary ____Progress Notes ____Consultation Reports ____History & Physical
_____X-Ray Reports ____Laboratory Tests ___ Other: _____

***(3) If you DO NOT WISH TO INCLUDE SENSITIVE INFORMATION IN THIS RELEASE, please check the applicable items that you DO NOT WISH TO BE RELEASED:***

*****DO NOT RELEASE***_____**AIDS/HIV, Sexually Transmitted Diseases ____Psychiatric/Behavioral Health
_____Drug/Alcohol Testing/Treatment ____Other_____

(4) This information is to be disclosed to _____ telephone/fax: _____

address: _____ for the purpose of _____.

(5) I understand this authorization may be revoked **in writing** at any time, except to the extent that action has been taken in reliance on this authorization. Revocation can be performed by submitting a request in writing to the specific entity/department which released the information, with a statement that the patient wishes to retract their prior authorization. **All written revocations should be dated and signed.**

(6) Unless otherwise revoked, this authorization will expire 90 days after the date of signature.

(7) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected. DHS has no responsibility or liability as a result of the re-disclosure.

(8) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(9) Davis Health System will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

(10) Failure to complete this form **in its ENTIRETY** may void the authorization for disclosure for PHI.

Signed (patient): _____ Date: _____

_____ _____ Date: _____
(or legal representative ) (Relationship to Patient)