Patient ID

Davis HealthSystem

Authorization for Disclosure of Health Information

(1) I hereby authorize____ to
(Name of provider)

disclose the following information from the health record(s) of:

Patient Name:____ **Date of Birth:**_____________________

Address:____**Telephone:**_______________________

____ **Patient Number:**__________________

covering the period(s) of healthcare: **From (date)**______________**To (date)**_________________

(2) Information to be disclosed: ____**Complete health record (s)** ____**X-Ray Films**

Or Only: ___Discharge Summary ____Progress Notes ____Consultation Reports
___History & Physical ____Laboratory Tests ____X-ray Reports
___Other:____

I understand that I am giving my permission to release copies of records that may contain information relating to AIDS/HIV, sexually transmitted diseases; psychiatric/behavioral health; drug/alcohol testing or treatment; unless otherwise **initialed** below:

Do **NOT** release: ____AIDS/HIV, sexually transmitted diseases. ____Psychiatric/behavioral health information.
____Drug/alcohol testing/treatment. ____Other_____________________________________

(3) **This information is to be disclosed to**____**for the purpose of**____

(4) 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.

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

(6) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected. This authorization shall only apply to the treatment record(s) of Davis Medical Center.

(7) 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.

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

Signed:(*patient*)____ **Date** _______________

____ **Date** _______________
(or Legal Representative) ***(Relationship to Patient***

PLEASE RETURN FORM TO THIS OFFICE
White copy/Office - Yellow copy/ patient

CL0010

Form 532 (Rev. 12/13)