HIGHLAND RIDGE HOSPITAL
LIVE LIFE ELEVATED

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Instructions:

Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____, Date of Birth: _____,
SS#_____
I, _____ authorize the information specified below to be disclosed as follows:
FROM: Highland Ridge Hospital 7309 South 180 West, Midvale, UT 84047
TO:
Name of Person: _____
Organization: _____
Address: _____
Phone: _____FAX (if applicable):_____

By signing above I hereby authorize Highland Ridge Hospital, or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS Information; and treatment received at other health care facilities. Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment **(check each item requesting):**

	YES	NO		YES	NO
Discharge Summary	_____	_____	Medication Regime	_____	_____
Initial Psychiatric Evaluation	_____	_____	Progress Notes	_____	_____
Medical History & Physical	_____	_____	Discharge Instructions	_____	_____
Laboratory Reports (**Excluding HIV**)	_____	_____	Other- **Specify**: _____	_____	_____

If information in my records pertains to HIV or AIDS, I expressly (do____), (do not____) authorize Highland Ridge Hospital to disclose such information pursuant to this authorization. Check if not applicable (____).

If the information in my records pertains to drug and/or alcohol abuse or dependence I expressly (do____), (do not____) authorize Highland Ridge Hospital to disclose such information pursuant to this authorization. Check if not applicable (____).

I am requesting that information be disclosed for the purpose(s) of: (Please Circle):
Continuation of Care Disability Patient Records Legal Other: _____

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on_____ (date cannot be more than 180 days after date signed below).

- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.
- I understand that Highland Ridge Hospital will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this information.
- I understand there is a $0.50 charge per page with a maximum allowance of $15 that may be applied to the copy, fax, or email of the requested health records.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Highland Ridge Hospital and its representatives, from all legal liabilities that may result from the release of this information according to this request.

Signature: _____ Relationship to patient: _____ Date signed: _____

Please provide necessary documentation if required.

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. 160-164) as well as 42 C.F.R. part 2 and 42 U.S.C.290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.