

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Jordan Hospital to use or disclose the following health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to **redisclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_

3. **Information to be disclosed to:** \_\_\_\_\_  
Name

Address: \_\_\_\_\_  
Street City State Zip

4. **Disclose the following information for treatment dates:** \_\_\_\_\_ to \_\_\_\_\_:

<input type="checkbox"/> Complete Records	<input type="checkbox"/> Consult	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Ray	<input type="checkbox"/> Emergency Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Outpatient Reports	<input type="checkbox"/> Pathology	_____

5. The above information is **disclosed for the following purposes:**

Medical Care  Legal  Insurance  Personal

6. I understand I may **revoke this authorization** at any time by requesting such of the above-referenced hospital/physician/facility in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization **expires** after ninety (90) days from the date I signed it unless otherwise specified.

7. Signature of Patient or Legal Representative

8. Date

9. Printed name of patient or patient=s representative

10. Relationship to patient or authority to act for patient (**attach documentation**)

11. I understand that my record may contain information in reference to treatment for substance abuse and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, or other sensitive information. I agree to its release unless otherwise specified (please explain).

12. Signature of Patient or Legal Representative

13. Date

14. Printed name of patient or patient=s representative

15. Relationship to patient or authority to act for patient (**attach documentation**)