Physician Group
OF UTAH, INC.

Authorization for Use and Disclosure of Protected Health Information

Patient Name: ____
(Please print) (Last) (First) (Middle)

Address: ____
(Street) (City) (State) (Zip)

Phone: ____________________ Date of Birth: ____________________ SS#: ____________________

I authorize ______________________________ to disclose protected health information to:

Name: ______________________________ Phone: ________________ Fax: ______________

Address: ____
(Street) (City) (State) (Zip)

Purpose for use/disclosure: ____

Date(s) of service to be used/disclosed: ____

Information to be used/disclosed (check all that apply):

- ☐ Entire Medical Record
- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Report(s)
- ☐ Operative/Procedure Report
- ☐ Lab Reports
- ☐ Pathology Report
- ☐ Radiology Reports/Films
- ☐ Other ____

Specific Authorization to Disclose Sensitive Records

I understand that this authorization is to include use/disclosure of (please initial):

_______ Alcohol and/or drug abuse records
_______ Psychiatric records
_______ Sexually transmitted disease information
_______ HIV/AIDS information

*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Physician Group of Utah has already relied on this authorization.
- I understand that I may revoke this authorization by mailing or faxing a written notice to the Regional Compliance and Privacy Officer, at Physician Group of Utah 406 W. South Jordan Parkway, South Jordan, Utah 84095 or fax to 801-984-3481, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is “none” unless otherwise specified here: Expiration: ____________________.
- I understand that Physician Group of Utah may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a “covered entity.”

SIGNATURE ______________________________________ DATE ____________________
(Patient or Patient’s Legal Representative)

Printed Name of Legal Representative: ____

Legal Representative’s Authority to Act for Patient: ______________________________________

PLEASE NOTE: THIS FORM MUST BE COMPETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

PGU010-0411