



Authorization to Use and Disclose Protected Health Information



Authorization to release the protected health information of:			
Patient Name:		MRN (office use Only):	
Current Address:	City:	State:	Zip:
Phone Number: ()		Date of Birth: / /	
This authorization is to release the protected health information to:			
Name:		Phone Number: ()	
Address:	City:	State:	Zip:
Deliver by: <input type="checkbox"/> In Person <input type="checkbox"/> Mail <input type="checkbox"/> By Phone <input type="checkbox"/> Fax — Fax Number: () <input type="checkbox"/> Secure Email — Email Address:			
This authorization is to release the protected health information from:			
Facility Name/Provider:		Phone Number: ()	
The purpose of this disclosure is:			
Dates of service requested:			
Release the following information:			
<i>Patient Health Information:</i>			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Report(s)		
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Report(s)		
<input type="checkbox"/> Operative Report(s)	<input type="checkbox"/> Lab Report(s)		
<input type="checkbox"/> Consultations	<input type="checkbox"/> Progress Notes		
<input type="checkbox"/> Treatment Plan(s)			
<input type="checkbox"/> Other Protected Health Information as specified:			
<i>Financial:</i>			
<input type="checkbox"/> Itemized Billing Statement	<input type="checkbox"/> Financial Information		
This Authorization will remain in effect:			
<input type="checkbox"/> From the date of this Authorization or until the following event occurs: _____			
Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.			

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to "this facility" to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Saltzer. If I revoke this Authorization, Saltzer may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility" treatment of me, enrollment in the health plan, or eligibility for benefits.
- If I have questions about disclosure of my health information, I can contact Saltzer or call (208) 463-3000.
- Si lo solicita, se le proveerá un servicio de interpretación gratis. Hable con un empleado del hospital para solicitarlo.
- If requested, we will provide you a free interpretation service. Talk to an employee of the facility to apply.

Signature of Patient or Personal Representative:	Date:
If Signed by Personal Representative, Relationship:	Signature of Witness (optional):