Print Clear

Authorization for Disclosure of Protected Health Information (PHI)

Patient Information

Full Name _____ Date of Birth _____

Maiden or Other Names Used _____

Address _____

City State Zip

Day Phone _____ Cell Phone _____

Release From I would like copies of my medical records from the following Intermountain Health facility or doctor.

Intermountain Health Hospital, Clinic, or Doctor Name _____

Release To

Person/Company/Organization Name _____

Address _____

City State Zip

Phone _____ Fax _____

Purpose

☐ Continuity of Care ☐ Insurance/WC ☐ Legal

☐ Health Oversite ☐ Law Enforcement ☐ Personal

Date(s) Of Information To Be Disclosed

Date(s) of Service from _____ through _____

Other _____

Information To Be Disclosed I would like copies of the items checked below for the above treatment dates.

☐ Clinic Visit ☐ History & Physical ☐ Laboratory ☐ Substance Use Treatment

☐ Emergency Report ☐ Discharge Summary ☐ Imaging Report ☐ Billing Record

☐ Operative Report ☐ Consultation ☐ Cardiac Study/EKG ☐ Other _____

Disclosure Format I would like copies of the items checked above in the following format (Paper–US Mail is default if not marked).

☐ Paper – US Mail ☐ CD ☐ Verbal only ☐ Fax (healthcare provider only)

☐ Paper – pick up ☐ USB ☐ Email to _____

Patient Access Information

- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.
- A Care Site professional will supervise the review of my medical record.
- If I am involved in a research study involving medical treatment, my access to the research study content may be suspended for as long as the research is in progress. At the completion of the research, access to my medical record will be reinstated.

I Understand That

- The information to be disclosed may include a diagnosis or reference to the following condition(s): behavioral health services/ psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
- Without my express revocation, this authorization will automatically **expire** 180 days from the date signed below, unless I request a specific expiration date or event _____. (Send revocation to the address or number below).
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule, unless the disclosure includes records from a federally-assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case **redisclosure is prohibited** under 42 CFR Part 2.

My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this Care Site may charge for copies of medical records.

_____

Patient/Guardian/Personal Representative's **Signature** Relationship (if not patient) Date

_____

Guardian/Personal Representative's **Printed** Name, Address, Phone

If patient is unable to sign, document reason: _____

CO, NV, MT, WY return completed form to:	• Email: peaks_croi@imail.org • Fax: 303-467-8966	• Mail: Centralized Release of Information 500 Eldorado Blvd, Building 4, Broomfield, CO 80021
UT, ID return completed form to:	• Email: MedRecReq@r1rcm.com • Fax: 385-215-7047	• Mail: Medical Records PO Box 571069, Murray, UT 84157

For Office Use Only

Date Authorization Received: _____ By: _____ Identification/Driver License Verified: _____

Date Request Completed: _____ By: _____ Delivery Instructions: _____

Intermountain Health

Enterprise

Patient Label

520380697 06/2025 / A-MR-0215-0625