ROSENBERG COOLEY METCALF
THE ORTHOPEDIC CLINIC AT PARK CITY

Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:		
Patient Name:	MR#	
Current Address		
Social Security #	Phone #	Date of Birth

This authorization is to release the protected health information to:
Name
Address

This authorization is to release the protected health information from:
Facility Name/Provider
Address
The purpose of this disclosure is:
Dates of service:

Release the following information:

☐ Discharge Summary	☐ Pathology report(s)	☐ Alcohol/Drug Treatment record(s)*
☐ History & Physical	☐ Radiology report(s)	☐ Itemized Billing Statement
☐ Consultations(s)	☐ Lab report(s)	☐ X Rays
☐ Operative report(s)	☐ Cardiology report(s)	☐ X Ray Copies ($5.00 ea)
☐ Progress Notes	☐ Psychiatric record(s)	☐ Other records as specified:
☐ Emergency record(s)	☐ Treatment Plan(s)	

Term: This Authorization will remain in effect:

☐ From the date of this Authorization until: _____

☐ 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 the Recipient will no redisclose 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.
- my records are protected and cannot be disclosed without my written permission. *Alcohol/drug treatment records are protected by Federal Rule 42 CFR, part 2.
- this Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Services Medical Record Department.

To be used if facility requests this authorization:

I understand that:

- 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's*" treatment of me, enrollment in the health plan, or eligibility for benefits.
- I may make a request in writing at any time to "*this facility*" to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.

If I have questions about disclosure of my health information, I can contact the Health Information Services/Medical Record Department.

Signature of Patient or Legal Representative	Date
If Signed by legal Representative, Relationship to Patient	Signature of Witness (optional)