Sacred Circle HEALTHCARE | A CTGR Entity

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

A: PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	B: PATIENT DATE OF BIRTH	C: LAST FOUR SSN (OPTIONAL) XXX-XX-_____
D: PATIENT ADDRESS:	E: REQUESTOR'S NAME/PHONE NUMBER (If patient is not the requestor) RELATIONSHIP TO PATIENT: ❑ SELF ❑ PARENT/GUARDIAN ❑ HIPAA ❑ OTHER (Please Specify) _____	
F: SACRED CIRCLE HEALTHCARE 660 S 200 E, STE 250, SLC, UT 84111 (T) 801.359.2256 (F) 801.364.4392	G: I AUTHORIZE THE FACILITY NAMED IN BOX "F" TO: ❑ RECEIVE PROTECTED HEALTH INFORMATION FROM THE ENTITY NAMED IN BOX "H" ❑ DISCLOSE PROTECTED HEALTH INFORMATION TO THE ENTITY NAMED IN BOX "H"	

OTHER FACILITY/PROVIDER/3RD PARTY INFORMATION

H: NAME AND ADDRESS:	I: ENTITY "H" PHONE NUMBER: J: ENTITY "H" FAX NUMBER:

PURPOSE FOR USE/DISCLOSURE

K: REASON:	L: APPROXIMATE DATE(S) TO BE DISCLOSED:

M: DOES THIS DISCLOSURE EXPIRE? ❑ Yes ❑ No (IF NO, AUTHORIZATION IS VALID UNTIL 1 YEAR FROM SIGNATURE DATE)

DATE OF EXPIRATION:

INFORMATION TO BE DISCLOSED

❑ ALL PHI	❑ PHYSICIAN ORDERS	❑ SPECIAL TEST/ THERAPY
❑ HISTORY AND PHYSICAL	❑ NURSING NOTES	❑ ITEMIZED BILLING/CLAIM RECORDS
❑ OFFICE VISITS	❑ MEDICATION RECORD	❑ CONSULTATION REPORT
❑ OPERATIVE/PROCEDURE REPORTS	❑ IMMUNIZATION RECORD	❑ PHARMACY RECORDS
❑ LAB REPORTS	❑ DEMOGRAPHICS	❑ OTHER:
❑ RADIOLOGY REPORTS/IMAGING	❑ REHABILITATION SERVICES	_____

I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE/DISCLOSURE OF (Please Initial)

❑ I ACKNOWLEDGE, AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, PSYCHIATRIC, HIV TESTING, HIV RESULTS OR AIDS INFORMATION _____ (Initials)

**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 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 Sacred Circle Healthcare has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a signed, written notice to Medical Records at Sacred Circle Healthcare at 660 S 200 E, Ste 250, SLC, UT, 84111 or fax to 801.364.4392, stating my intent to revoke authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing dating this form, unless otherwise documented in box "M".
- I understand that Sacred Circle Healthcare may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that the 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: (Patient or Patient's Legal Representative)	DATE:
PRINTED NAME: (Patient or Patient's Legal Representative)	DATE: