



OGDENCLINIC

Incoming Release for Protected Health Information

ROI/HIPAA

Name of Patient:
Address:
City:
State:
Zip:
Phone #:
Social Security #:
Birth date:

Relationship to Patient if not self:

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral and mental health services and treatment for alcohol and/or drug abuse. I hereby consent to the release of this information. This information may be disclosed to and used by the following individual or organization. INITIAL
***Alcohol/drug treatment records are protected by Federal Rule 42 CFR, part 2.

I hereby authorize:

FacilityName/Provider/Other:
Phone
Fax
Address
City
State
Zip

To Release:

MEDICAL DATA/INFORMATION

- Most Current Visit with Lab & X-Ray
Immunizations
6 Month Medical History
1 Year Medical History
2 Year Medical history
5 Year Medical History
Pathology Reports
EKG Reports
Insurance Billing Data
Radiology Reports
Laboratory Reports
Other* (Date Needed)

To: (Provider Name)

Ogden Clinic Medical Records
1491 East Ridgeline Drive
South Ogden, UT 84405
Fax: (801) 475-3454
Phone: (801) 475-3000

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Ogden Clinic's Privacy Officer at 1491 East Ridgeline Drive, South Ogden, Utah 84405. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Authorization Required Below

Signature of Patient or Legal Guardian:
Date:

Created by: HIPAA Privacy Sub-committee
Approval: Forms Committee
Revisions Date: 10/12/2013AW 05/28/15 MH
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