CEDAR RIDGE
FAMILY MEDICINE

PATIENT AUTHORIZATION

for Use or Disclosure/RELEASE of Medical Information

(Required under HIPAA – Health Insurance Portability and Accountability Act of 1996)

(Required When Patient Requests Specific Medical Records to be Sent Somewhere by Cedar Ridge Family Medicine) (315.6)

I hereby authorize the use or disclosure of my protected health information as described below and understand and acknowledge the following:

- I am not required to sign this authorization and may refuse to sign. However, if I do not sign, my records cannot be sent to anyone else.
- Cedar Ridge Family Medicine will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
- If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
- I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Cedar Ridge Family Medicine, 110 West 1325 North, Suite 200, Cedar City, Utah 84720. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization. If I do not revoke this authorization in writing I will not hold Cedar Ridge Family Medicine responsible for releasing my protected health information per the authorization at a future date for unwanted content.
- If I have any questions about this authorization, I may contact Cedar Ridge Family Medicine's HIPAA Officer at (435) 586-7676 who will provide me with more information about this authorization, or about Cedar Ridge Family Medicine's privacy practices.

I. _____ ____/____/____ XXX-XX-_____

Name of Patient (legibly) Date of Birth SSN (Last 4 digits) for verification

II. This authorization applies to the specific information set forth below. (Please indicate what is being sent)

☐ All Records
☐ Immunizations
☐ Progress notes only
☐ Sensitive info/mental health/STD's, etc.
☐ Imaging/X-Ray from Date: _____
☐ Lab Results from Date: _____
☐ Medication List/Allergies/Orders/Referrals
☐ Other:_____

III.

- I authorize the Cedar Ridge Family Medicine **to use or disclose** my protected health information to the following person or organization:

Name: _____ Relationship to Patient: _____

Mailing Address: _____ Phone: _____

_____

_____ Fax: _____

IV. Reason for Release:

☐ Moving out of Cedar City
☐ Personal use
☐ Employer or work
☐ Other: _____
☐ Changing to another doctor or provider
☐ Referral to another servicing provider
☐ School/educational purposes

V. The use or disclosure of the requested information in this authorization may result in direct or indirect compensation to Cedar Ridge Family Medicine from a third party. This form for requested medical information will remain in effect for 60 days after the date originally signed. I certify that I have read, signed, and received a copy of this authorization.

_____ ____/____/____ _____

Patient or Representative Signature Date Relationship to Patient

_____

Witness Signature