



University of Utah
Health Sciences Center

PATIENT AUTHORIZATION

DISCLOSURE OR RECEIPT OF PROTECTED HEALTH INFORMATION

Name of Patient _____ Medical Record # _____

Date of Birth _____ Phone # _____

Patient Address _____

Soc. Sec. # _____ (Providing your SS# is voluntary, but necessary to accurately identify your medical records. Failure to provide this information will likely delay the processing of your request).

Approximate Dates of Treatment _____

1. I authorize the following health care provider or facility **TO DISCLOSE** my patient information:

- _____ University Hospital (Inpatient) _____ University Neuropsychiatric Institute (UNI)
- _____ Community Clinics _____ Sugarhouse Clinic _____ Madsen Clinics
- _____ Moran Eye Center _____ Huntsman Cancer Institute
- _____ Outpatient Clinic(s): _____
- _____ Specific Provider(s): _____
- _____ Other: Name: _____ Phone: _____

Address: _____

2. I authorize the following person or organization **TO RECEIVE** my patient information:

Name/Credentials: _____ Relationship: _____

Address: _____

_____ Phone # _____

3. Please disclose the following information: (circle to indicate your selection)

- | | | |
|-----------------------------|--------------------------|----------------------|
| History and Physical | Psychological Evaluation | Discharge Summary |
| Educational Reports | Treatment Plans | Psychosocial History |
| Radiology and Lab Reports | Consultation Reports | Immunizations |
| Outpatient Clinical Records | | |

Other: _____

