PIONEER VALLEY HOSPITAL, A CAMPUS OF JORDAN VALLEY MEDICAL CENTER
3460 S. 4155 W., West Valley City, Utah 84120
Phone: 801-964-3150 Fax: 801-964-3467

Authorization for Use and Disclosure of Protected Health Information

Patient Name_____
(please print) Last First Middle
Address_____
Street City State Zip
Phone_____Date of Birth_____SS#_____

I authorize Pioneer Valley Hospital, A Campus of Jordan Valley Medical Center to use or disclose protected health information to:

Name:_____Phone/fax number:_____
Address:_____

Purpose for use/disclosure:_____

Date(s) of service to be used/disclosed:_____

Information to be used / disclosed:
___Emergency Room Record
___History and Physical
___Operative/procedure report
___Pathology report
___Entire Medical Record
___Discharge summary
___Consultation report(s)
___Lab reports
___Radiology reports/films
Other_____

Specific Authorization to Disclose Sensitive Records
I understand that this authorization is to include use / disclosure of (please initial):
____Alcohol and/or drug abuse records
____Sexually transmitted disease information
____Psychiatric records
____HIV/AIDS information
*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information without the 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 Pioneer Valley Hospital, A Campus of Jordan Valley Medical Center has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Regional Compliance and Privacy Officer, at Pioneer Valley Hospital, A Campus of Jordan Valley Medical Center, 3460 S. 4155 W., West Valley City, Utah 84120 or fax (801) 964-3247, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which the authorization expires is: _____.
- I understand that Pioneer Valley Hospital, A Campus of Jordan Valley Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that 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_____DATE_____
Patient or Patient's Legal Representative

Printed Name of Legal Representative:_____
Legal Representative's Authority to Act for Patient:_____

PLEASE NOTE: THIS FORM MUST BE COMPETED IN ITS ENTIRETY, THANK YOU FOR YOUR COMPLIANCE.