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 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 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.

II. _____ _____/_____/_____ _____-_____-_____
Name of Patient (legibly) Date of Birth Social Security Number for verification

III. This authorization applies to the specific information set forth below.

_____

_____

IV. I authorize the following persons or organizations to use or disclose of my protected health information:

[ ] ***Cedar Ridge Family Medicine*** [ ] Other _____

V. I authorize the following persons or organization to receive my protected health information listed above:

[ ] As deemed necessary by Cedar Ridge Family Medicine [ ] Other _____

VI. This authorized use or disclosure is for the following specific purpose (s):

[ ] As deemed necessary by Cedar Ridge Family Medicine [ ] Other _____

VII. 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.

_____ _____/_____/_____ _____
Signature of Patient or Representative (Legibly) Date Relationship (if representative) to Patient

_____
Signature of Witness (Legibly)