BEAVER VALLEY HOSPITAL

Patient Authorization
Disclosure or Receipt of Protected Health Information

Name of Patient _____ Date of Birth _____

Patient Address _____

Phone # _____ Cell Phone # _____ Soc. Sec. # _____

Approximate Dates of Treatment _____

1. I authorize Beaver Valley Hospital to release my patient information to the following: (please choose one)
   Mailing Address: _____
   Person to pick up: _____ Relationship: _____
   Email: _____
   Fax #: _____
   Physician: _____ Fax # or address: _____
2. Please Disclose the following information: (circle to indicate your selection)

History and Physical	Discharge Summary	Consultations	Operative Report	Progress Notes
Emergency Records	X-Ray/Disc	Cardiology	EKG Reports	Lab and Pathology

Other: _____

These requests may be billed at a cost of $.50 per copied page with a $20.00 search fee. Prepayment may be required.

I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulation, the information he/she receives will no longer be protected by these regulations and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to Beaver Valley Hospital 1109 North 100 West, Po Box 1670 Beaver, UT 847103. I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one)

_____ 1 year from the date of signature _____ one time disclosure only

_____ _____

Patient Name (print) Patient Signature Date

_____ _____

Witness Witness BVH workforce member Date

SUBSCRIBED AND SWORN before me this _____day of _____20_____

Street address: _____

City, State and Zip Code: _____ _____

NOTARY PUBLIC

My commission expires: _____