Gagon Family Practice
Authorization to Use and Disclose Protected Health Information
To our office

Authorization to release the protected health information of:

Patient Name:_____ Social Security Number_____ Date of Birth_____
Current Address:_____City:_____State_____Zip_____ Phone _____

This authorization is to release the protected health information to:

Name: Dr Gagon, Dr Valdez, Donna Mathis, Lindsey Rux, Amanda Lively, Kashley Jones, Camrey Tuttle
Phone Number: (435) 613-2200 Fax Number: (435) 613-2201
Address: 377 N Fairgrounds Rd City: Price State: Utah Zip: 84501

This authorization is to release the protected health information from:

Name:_____ Phone Number_____ Fax Number_____
Address:_____City:_____ State_____ Zip_____

The purpose of this disclosure is:_____

Dates of service requested:_____

Release the following information:

___Discharge Summary	**___Pathology report(s)**	**___Itemized Billing Statement**
___History &Physical	**___Radiology report(s)**	**___Psychiatric Admitting Evaluation**
___Consultation(s)	**___Lab report(s)**	**___Psychiatric Discharge Summary**
___Operative Report(s)	**___Cardiology report(s)**	**___Psychiatric Testing**
___Progress Notes	**___Treatment plan(s)**	**___Other records as specified:_____**
___Emergency record(s)	**___Alcohol/Drug Treatment***	**_____**

This authorization will remain in effect:

___ Until the following event occurs:_____

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that the Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to "this facility" to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Management/Medical Record Department. If I revoke this Authorization, Castle Country Family Medicine may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.

To be used if facility requests this authorization:

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility's" treatment of me.
- I may make a request in writing at any time to this facility to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR 164.524.

*Alcohol/Drug treatment records are protected by Federal Rule 45 CFR, part 2. Both a minor's and a parent/guardian's signature must be obtained prior to disclosing the minor's alcohol/drug treatment records.

If I have any questions about disclosure of my health information, I can contact the Health Information Management / Medical Record Department.

Patient Signature_____ Date_____
Witnessed_____ Date_____