Green River Medical Center
585 West Main Street, Box 417
Green River, UT 84525-0417
Phone: (435) 564-3434 | Fax: (435) 564-3214

For Release and/or Disclosure of Health Information

I authorize the disclosure of my **personal health information (PHI),** which includes my medical records, to the persons/entities as described below.

- I understand this authorization is voluntary, and made to confirm my directions.
- I understand that once the information is disclosed, it may be re-disclosed by the person/entity that receives it. In this case, my information may no longer be protected by federal privacy regulations.
- I give permission to Green River Medical Center (GRMC) to disclose my personal health information in the manner described herein.

PARTICIPANT'S INFORMATION		
Name:		SSN#:
Birthdate:	Contact Phone Number:	Request Date:
MY PHI MAY BE DISCLOSED TO:		
Person/Facility:	Phone #:	Fax#:
Address:		
MY PHI MAY BE REQUESTED FROM:		
Person/Facility:	Phone #	Fax#
Address:		

PERSONAL HEALTH INFORMATION TO BE DISCLOSED

1. Specify records to be released and /or disclosed (check all that apply):

- o **General Medical Information (from_____to_____)**
- o **Information Regarding Specific Injury or Treatment:_____(from_____to_____)**
- o **X-Ray/Laboratory Results of:_____(from_____to_____)**
- o **Alcohol/Drug (from_____to _____) Initials of Participant or Representative _____**
- o **HIV Test Results (from ____to_____) Initials of Participant or Representative _____**
- o **Immunizations** o **Pap Smear** o **Mammogram** o **Colonoscopy**
- o **Other (specify)_____**

Right to Revoke: I understand that I may revoke this authorization in writing at any time.

I understand my revocation will NOT affect any disclosures that occurred before GRMC received and processed my written notice of revocation.

I understand that if I did not specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below.

ACKNOWLEDGEMENT

Please sign and date: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Green River Medical Center to release nonpublic personal health information. I understand that Green River Medical Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

By: _____ _____ _____
Participant's Name (Print) Participant's Signature Date

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, legal guardian)

By: _____ _____ _____
Signer's Name (Print) Signer's Signature Date

□ **Parent of Minor Child** □ **Legal Guardian** □ **Power of Attorney** □ **Self** □**Other**

Revised 10/04/2016