



# GRANITE PEAKS GASTROENTEROLOGY

## Authorization to Disclose Protected Health Information

Patient Name:		
Mailing Address:		
	City:	State:      Zip:
Social Security Number:	Phone Number: (      )      -	Date of Birth: /      /
Release the following <b>protected information</b> to:		
Name:		
Address:		
	City:	State:      Zip:
Phone Number: (      )      -	Fax Number: (      )      -	Email Address:
Authorization to release <b>protected information</b> from:		
Sender Name: <b>Granite Peaks Gastroenterology</b>		
Address: :		
<b>9829 S. 1300 E. Suite 300/303</b>	<b>Sandy</b>	<b>UT      84094</b>
Phone Number: ( <b>801</b> ) <b>619</b> - <b>9000</b>	Fax Number: ( <b>801</b> ) <b>619</b> - <b>9001</b>	Email Address:
Release the following information:		
<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Procedure Report(s)	<input type="checkbox"/> Other records: _____
<input type="checkbox"/> Office Follow-up(s)	<input type="checkbox"/> Radiology Reports(s)	_____
<input type="checkbox"/> Laboratory Report(s)	<input type="checkbox"/> Itemized Billing Statement	_____
<input type="checkbox"/> Pathology Report(s)	<input type="checkbox"/> <b>All Chart Records</b>	_____
This authorization to remain in effect until:		
Date: _____		
<b>OR</b>		
Until the following event occurs: _____		
<small>Unless otherwise noted above, this authorization will remain in effect 180 days from the date signed.</small>		
<b>I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF THE INFORMATION DESCRIBED ABOVE AND UNDERSTAND AND ACKNOWLEDGE THAT:</b>		
<ul style="list-style-type: none"> <li>▪ If I have any questions about this authorization or the disclosure of my health information, I may contact Granite Peaks Gastroenterology, P.C. at (801)619-9000.</li> <li>▪ Once Granite Peaks Gastroenterology, P.C. discloses my health information as requested, 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 and state law governing the use and disclosure of my health information.</li> <li>▪ I may make a request in writing at any time to Granite Peaks Gastroenterology, P.C. 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.</li> <li>▪ I have the right to revoke this authorization. The revocation must be in writing and submitted to Granite Peaks Gastroenterology, P.C.</li> <li>▪ Granite Peaks will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is for research related treatment or another qualifying event.</li> </ul>		
Patient Signature or Legal Representative:		Date: /      /
Relationship to Patient if signed by Legal Representative:		Signature of Staff Witness: