GRANITE PEAKS GASTROENTEROLOGY

AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION

I, _____/ _____
PATIENT NAME (PLEASE PRINT) PATIENT DATE OF BIRTH

authorize Granite Peaks Gastroenterology to make the following disclosures of my protected health information:

- ☐ Prescriptions
- ☐ Laboratory reports
- ☐ Notes on medical progress
- ☐ Procedure reports
- ☐ Other: please specify below: _____
- ☐ X-rays, MRIs and/or other imaging reports
- ☐ Pathology reports
- ☐ Billing, Explanation of Benefits & Payments
- ☐ Record & notes from one office visit or one procedure. Please give date of visit or procedure:_____

☐ Complete medical record (all information in my chart): Please sign below if you want us to disclose your *complete* medical record:

_____ _____ /_____/_____
(To authorize disclosure of *complete* medical record, Patient must sign here) Date

I authorize Granite Peaks GI to release the protected health information listed above to the following entity or persons: (Please write the person or entity you want to receive your private health information and their contact information):

_____
Name of Intended Recipient(s)

_____
Address, City, State, Zip Code

_____ _____
Telephone number Fax number

I want to disclose my private health information to the above person or entity for the following purpose(s) or reasons:

_____
_____

(If patient does not wish to disclose his or her reasons or does not give a reason, please write: "At the request of the individual" in the above blank space).

I WANT THIS AUTHORIZATION TO EXPIRE EITHER:

On the following date: _____
or when the following event occurs: _____

THESE ARE YOUR RIGHTS:

- **You have the right to REVOKE this authorization at any time. The revocation must be in writing, signed by you and received by Granite Peaks Gastroenterology.**

- If we receive your revocation *after* we have already disclosed your private health information based upon your earlier Authorization, then your revocation will not apply to any information which has already been released to a third party.

- Once we disclose your private health information pursuant to your Authorization, we cannot guarantee that the recipient will not disclose your protected health information to others. This is because the entity or person you authorized to receive your private health information may not be required to abide by federal and state privacy laws.

- Granite Peaks Gastroenterology will not condition your receiving medical care upon your signing this Authorization.

- If you have any questions, please contact Kristen Staley, Privacy Officer for Granite Peaks Gastroenterology at (801) 727-2036.

_____ _____
SIGNATURE OF PATIENT or PATIENT'S REPRESENTATIVE **DATE**

If you are not the patient, please indicate below your relationship with the Patient:

☐ Parent ☐ I am a Court-appointed Guardian
☐ Executor of Deceased Patient's Estate ☐ I have a valid Power of Attorney
☐ Other Representative_____
Please specify nature of representation

STAFF MUST PROVIDE YOU WITH A COPY OF THIS SIGNED AUTHORIZATION.

REVOCATION OF AUTHORIZATION

I REVOKE this authorization effective on _____/_____/_____.
Month Day Year

Signed: _____ _____
Patient or Patient Representative Date