FORM PROCESSING

Please allow 7-10 business days to complete your request.

Today's Date________________

Patient Name____________________________

Date of Birth____________________________

- **DISABILITY FORMS:**

Beginning date:___________________

Ending date:_____________________

Reason:____

- **OTHER FORMS:**

Dates (if applicable)____

Reason:____

____

Name of doctor to sign form:______________________________________

If the doctor is unavailable to sign, can another doctor sign? ___Yes ___No

____I will pick up the completed form at the reception area

____Mail the form to:_______________________________________

____

____

___Fax the form to:____

Taken By:_______________

Southern Utah Women's Health Center, P.C.
515 S. 300 E. Suite 206
St. George Utah 84770
Phone: 435-628-1662 / Fax: 435-673-7124

Craig D. Astle, M.D.
Brady N. Benham, M.D.
Coby T. Brown, M.D.
Tracy W. Winward, M.D.
Pamela J. Sorensen, PA-C
Brittany Duckett, FNP

Authorization to Use and Disclose Protected Health Information

Authorization to release the health information of:

Patient Name:*______________________________ Account #____________

Current Address:*____________________ City*______________ State*____ Zip*_____

Social Security Number:*____________ Phone #:*______________ Date of Birth*__________

***MUST BE FILLED IN COMPLETELY**

This authorization is to release protected health information to:

Name:*______________________________ Phone #*________________

Address:*__________________________ City*____________ State*____ Zip*______

FAX #______________________ ***MUST BE FILLED IN COMPLETELY**

This authorization is to release protected health information from:

Southern Utah Women's Health Center, P.C.
515 S. 300 East Suite 206
St. George UT 84770
FAX: 435-673-7124

The purpose of this disclosure is: ☐ Patient Request ☐ Treatment ☐ Payment Purposes ☐ Other__________________

Release the following information:

- ☐ All treatment or examination records:______________________________
- ☐ Specific test or treatment:______________________________
- ☐ Treatment date:______________________________

This authorization will remain in effect:

- ☐ From the date of this authorization until:______________________________
- ☐ Until the following event occurs:______________________________

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

•I hereby release Southern Utah Women's Health Center, P.C. and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized.

•I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, mental illness, psychiatric treatment or any other medical condition.

•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 and state law governing the use and disclosure of my health information.

•I may make a request in writing at any time to Southern Utah Women's Health Center, P.C. to inspect and/or obtain a copy of my health information maintained in this facility as provided in the Federal Privacy Rule 45 CFR 164.524.

•My records are protected and cannot be disclosed without my permission. *Alcohol/drug treatment records are protected by federal rule 42 CRF, part 2.

•This authorization will remain in effect until Authorization expires or I provide written notice of revocation to the medical records department of Southern Utah Women's Health Center, P.C. If I revoke this authorization, *this facility* may not be able to reverse the use or disclosure of my health information while the Authorization was in effect.

Signature of Patient or
Legal Representative______________________________ Date:______________

If Signed by Legal Representative,
Relationship to Patient____________________ Witness (optional)____________________

Please Check One: Fax Records to the Fax # Shown Above Mail Records to Address Shown Above
I will pick up the Records when notified at the Phone # Shown Above

Please allow 14 business days

For Office Use Only: Given to Patient By_____ Date______

Date Faxed/Mailed__________ By______ Date Faxed/Mailed__________ By_______ Date Faxed/Mailed________ By_______