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________