HILTON HEALTHCARE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Hilton Healthcare LLC
2136 Harmony Pl., Bsmt Clinic, St. George, UT 84790 | Phone: 435-271-3524 | Fax: 435-271-3525
Email: barbara.hilton@hiltonhealthcare.com | **Website:** https://hiltonhealthcare.com

PATIENT INFORMATION

Patient full legal name: _____

Date of birth: _____ **Phone:** _____

Address: _____

I AUTHORIZE:

Provider / facility / person releasing records: _____

Address: _____

Phone: _____ **Fax:** _____

TO RELEASE INFORMATION TO:

Provider / facility / person receiving records: _____

Address: _____

Phone: _____ **Fax:** _____

INFORMATION TO BE RELEASED (check all that apply)

☐ Complete medical record ☐ Office/progress notes ☐ Lab results ☐ Imaging/radiology ☐ Medication list
☐ Immunization record ☐ Billing records ☐ Other: _____

Date(s) of service: _____ to _____

Purpose: Continuity of care / Personal use / Insurance / Legal / Other: _____

SENSITIVE INFORMATION

I specifically authorize release of the following, if present and if additional authorization is required by applicable law:

☐ Mental/behavioral health ☐ HIV/AIDS-related information ☐ Genetic testing ☐ Substance use disorder records

PATIENT AUTHORIZATION

I authorize the use or disclosure of the health information described above. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility for benefits generally may not be conditioned on signing this authorization except as permitted by law. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy law, except where other laws continue to protect it.

Expiration: This authorization expires one year from the date signed unless I specify an earlier date or event: _____

Patient / personal representative name: _____

Electronic or handwritten signature: _____ **Date:** _____

If personal representative, relationship/authority: _____

A copy or electronic version of this authorization is as valid as the original. The patient or personal representative is entitled to a copy of the signed authorization.