OnSiteCare
Affordable Healthcare at Work

230 South 500 East
Salt Lake City, UT 84102
Phone 801-320-5660, Fax 801-320-5661

560 South 300 East, Suite 2775
Salt Lake City, UT 84111
Phone 801-441-1002, Fax 801-441-1005

PATIENT AUTHORIZATION OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________________ Medical Record # _________________________

Date of Birth: ______________ SS# ______________________ Phone # _____________________________

Patient Address: ____

1. I authorize the following health care provider or facility to DISCLOSE my patient information:

   ☐ Outpatient Clinics(s) ____
   ☐Specific Provider(s): ____
   ☐Other: Name/credentials: ____
   Address: ____

   Phone: ___________________ Relationship to Patient: _____________________________

2. Please disclose the following information: (check all that apply)

   ☐History and Physical ☐Psychological Evaluation ☐Discharge Summary
   ☐Educational Report ☐Treatment Plans ☐Psychosocial History
   ☐Consultation Reports ☐Immunizations ☐Operative/Procedure Notes
   ☐Outpatient Clinical ☐ Records Radiology and Lab Reports
   ☐Other: ____

3. Please indicate the purpose of the disclosure of your patient records: ________________________________

   Check here if it is for your own personal use: ☐

4. If applicable, I understand that based on the dates, providers, and information I have designated above, the disclosure the healthcare provider makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

5. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal regulations, the information they receive will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that the healthcare provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: OnSite Care, 560 S 300 E, Suite 275SLC, UT 84111

8. I understand that my renovation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (Check One)

☐ Year from date above ☐One time disclosure only ☐ Other _______________

____ _____________________________

Signature of patient or patient representative Date

____ _____________________________

Name of patient representative Relationship to patient

Signature must be verified by OnSite Care staff or must be notarized

___________________________ _______________________________ _______________________________

Staff Signature Staff Printed Name Date

SUBSCRIBED AND SWORN before me this _____________ day of _____________, 20________

NOTARY PUCLIC

Residing in ________________________________

My commission expires: ____________________