ROCKY MOUNTAIN MS CLINIC
370 East 9th Avenue, Suites 106, 111, and 208
Salt Lake City, Utah 84103
Phone 801-408-5700 Fax 801-408-5704

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ **Birth Date** _____

Address _____ **Social Security #** _____

_____ **Phone** _____

Information listed below will be disclosed from:

_____
Name of Person or Organization

_____
Address

_____
Phone Fax

Information listed below will be disclosed to:

_____
Name of Person or Organization

_____
Address

_____
Phone Fax

Information to be used or disclosed

_____

_____

_____

Provide a statement describing each purpose for the requested use or disclosure of your information

_____

_____

Expiration Date or Authorization

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate of Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation, as described in the Notice of Privacy Practices, to Rocky Mountain Neurological Associates at the address above.

Potential for Re-Disclosure

If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the release of information may be re-disclosed and would no longer be protected.

Conditioning of Treatment

Rocky Mountain Neurological Associates physicians may not condition treatment of the provision of an authorization, except if treatment is research-related or solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I have read, signed and received a copy of this authorization.

_____

Name of Patient (type or print) Date of Birth

_____

Signature of Patient Date Signed

_____

Signature or Patient Representative

_____

Relationship of Patient Representative to Patient