ADVANCED SURGERY CENTER OF NORTHERN UTAH

HIPAA RELEASE FORM

In order to best serve our patients, and communicate regarding their services and financial obligations, we will use all methods of communication provided to expedite those needs. By providing the information below I agree that Advance Surgery Center of Northern Utah, or one of its legal agents, may use the telephone numbers provided to send me a text notification, call, or leave a voice message on an answering device. If an email address has been provided, Advance Surgery Center of Northern Utah, or one of its legal agents, may contact me with an email notification regarding my care, our services, or my financial obligation.

Patient	Name:	Date of Birth:
	Address:	
	Primary Phone:	Secondary Phone:
	Email:	

Authorization to Use and Disclose Protected Health Information

Other than you (the patient), your insurance company, and any health care providers involved in your care, is there any one else you give us authorization to release your protected health information? If so please list them below.

Authorized Party	Name:	Relationship:
	Phone Number:	
	This authorization for release of information covers the period of healthcare… ☐ all past, present and future periods **OR** ☐ from _____ through _____	

Authorized Party	Name:	Relationship:
	Phone Number:	
	This authorization for release of information covers the period of healthcare… ☐ all past, present and future periods **OR** ☐ from _____ through _____	

_____ _____
Signature of the Patient/Guardian/Legal Representative Date

_____ _____
(If not signed by Patient) Print Name Relationship to Patient

_____ _____
Witness Date

Patient Label