Central Utah Clinic, PC
Your Health, Your Choice.℠

1055 N. 500 W. Provo, UT. 84604 P| 801-429-8062 F| 801-374-2615

AUTHORIZATION TO **RELEASE** PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____, authorize Central Utah Clinic, P.C. to disclose to:
(Patient or Legal Representative(s))

Name: _____DOB:_____ Phone: _____

Name: _____DOB: _____ Phone: _____

Name: _____DOB: _____ Phone: _____

The following protected health care information (check one):

❑Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.)

❑Entire medical record for specified date(s) of service: From: _____ To: _____

❑ONLY the following specific information: _____

_____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

• Psychological / psychiatric conditions • Drug and/or alcohol abuse diagnosis and/or treatment • Genetic testing
• HIV/AIDS diagnosis and/or testing • Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions: _____

The purpose of the disclosure is: _____

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Photocopy: A photocopy of this authorization, including a copy that is received by fax or electronically transmitted, shall be considered as effective and valid as the original.

Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year or as otherwise noted below.

Expiration Date: _____/_____/_____

Signature of Patient or Legal Representative(s): _____
(Note: If patient is a minor child, both parents may be required by law to sign)

Date: _____/_____/_____ Printed Name(s): _____

Relationship to Patient (if signed by other than patient)_____