

UTAH COUNTY HEALTH DEPARTMENT
Authorization for Release of Information
YOU WILL RECEIVE A RESPONSE IN 2-3 BUSINESS DAYS
FROM THE TIME WE RECEIVE YOUR FAX

PATIENT NAME: _____
Last First MI Maiden or Other Name

DATE OF BIRTH: _____ - _____ - _____

I authorize the release of information held by the Utah County Health Department (UCHD) to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

I authorize the release of information held by _____ to the Utah County Health Department (UCHD).

Please send material to:
 Utah County Health Department
 151 S University Ave #1610
 Provo, UT 84601
 Phone: 801-851-7025 Fax: 801-851-7055

INFORMATION TO BE RELEASED:

<input type="checkbox"/> History and physical exam <input type="checkbox"/> Nursing Notes <input type="checkbox"/> X-ray reports <input type="checkbox"/> Immunizations <input type="checkbox"/> Cholesterol	DATES _____ _____ _____ _____	<input type="checkbox"/> STD <input type="checkbox"/> HIV related information <input type="checkbox"/> Incident/Short encounters <input type="checkbox"/> Other: _____	DATES _____ _____ _____
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PURPOSE OF DISCLOSURE:

<input type="checkbox"/> Changing Physicians	<input type="checkbox"/> Consultation/second opinion	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Personal
<input type="checkbox"/> School	<input type="checkbox"/> Insurance	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Legal			

1. I understand that this authorization will expire **90 days** after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and that it will be effective on the date written notice is received (except to the extent of action taken prior to receiving the written notice).
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. By authorizing this release of information, I understand that my health care and payment for my health care will not be affected.
5. I understand that I may have a copy of the information described on this form and a copy of this form after I have signed it.
6. I have been informed that Utah County Health Department will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

 SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

 RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____