AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE RELEASE MY RECORDS

☐ **I WOULD LIKE MY RECORDS SENT TO:** Utah Valley Pediatrics, L.C., PHONE#: _____ FAX#: _____
Address_____ City_____ State_____ Zip_____
FROM: Name_____ PHONE#:_____ FAX#:_____
Address_____ City_____ State_____ Zip_____

OR

☐ **I WOULD LIKE MY RECORDS SENT FROM:** Utah Valley Pediatrics, L.C.
TO: Name_____ PHONE#:_____ FAX#:_____
Address_____ City_____ State_____ Zip_____

OR

☐ **I AUTHORIZE MY PROTECTED HEALTH INFORMATION MAY BE RELEASED TO**: _____
who is _____ to the patient.

Full Names of Patient's Father & Mother: _____
Home Phone Number: _____ **Alternate Phone Number:**_____

Authorization to release the health information of:

Patient's Full Name Social Security Number	Date of Birth	Vaccines	Office Records	Hospital Records	Labs	Other
	/ /					
	/ /					
	/ /					
	/ /					
	/ /					

The purpose of this disclosure is: ☐ Patient Request ☐ Treatment ☐ Payment Purposes ☐ Other:_____

This Authorization will remain in effect:

- ❑ From this date of this authorization until:_____.
- ❑ Until the following event occurs:_____.

Unless otherwise noted above, this Authorization will remain in effect 180 days from the date signed.

I understand that:

- Once Utah Valley Pediatrics discloses my health information by my request, it cannot guarantee that recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- My records are protected and cannot be disclosed without my permission. *Alcohol/drug treatment records are protected by Federal Rule 42 CFR, part 2.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to Utah Valley Pediatrics.

To be used if Utah Valley Pediatrics requests this authorization:

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment.
- I make a request in writing at any time to Utah Valley Pediatrics to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.
- If I have questions about disclosure of my health information, I can contact Utah Valley Pediatrics Privacy Officer, Kevin Moffitt, at (801) 373-8930 or in writing at 1355 North University Ave. #210, Provo, UT 84604.

Signature of Patient or Legal Representative	Date
Relationship to Patient	Signature of Witness (Optional)

FOR OFFICE USE ONLY

Verify ID: Type Employee Initials:	☐ Mailed / /	☐ Faxed / /	☐ Hand Delivered / /

FEE

☐ No Charge (Copies for physicians or insurers with which we have a contract are provided at no charge.) ☐ Amount Paid: $_____ ☐ Cash ☐ Visa/MC ☐ Check	☐ Search fee: $20.00 (Waived for personal copy) ☐ Postage: $5.00 ☐ First 10 pages: $10.00 ☐ Additional pages: $.30 each