



Authorization for SLVHD to Release Records

(HIPAA Covered Programs Only)

I hereby authorize the disclosure of my protected health information (PHI) (or that of an un-emancipated minor child for whom I have legal authority) as described below. **I understand that this authorization is voluntary.** I understand that any information released may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.

THIS AUTHORIZATION IS FOR RELEASE OF PHI FOR CLIENT: _____

Client Identifying Information: DOB: ____ / ____ / ____ Address: _____
Ph : #: _____

Release information from (person/organization providing the information):

Release Information to (Name or identifying information):

Purpose of the disclosure: Medical Care ; Client Request ; Other (specify): _____

PHI to be released (describe information): _____

This authorization is limited to PHI created during the time period from: _____ to _____.

I also understand that I may limit the information to be released by specifying only those records needed. I further realize that if I authorize all of my records to be released, that SLVHD will follow my instructions to the extent release is allowed.

The client or the client's personal representative must read and initial the following statements:

I understand that:

1. I may revoke this authorization at any time with written notification to the Privacy Officer, Privacy Coordinator or designee sent to the address on the back. If I do revoke, I understand that this Decision will have no effect on actions taken prior to receiving the revocation. Initial: _____
2. **My health care and payment for my health care will not be denied if I do not sign this form.** Initial: _____
3. This authorization expires on: _____ (date) or, upon the occurrence of _____ (event). Initial: _____
4. There may be a charge for complying with this request. Initial: _____
5. I will receive a copy of this form after I sign it. Initial: _____

Signature of Client (or Personal Representative) **Relationship to Client** ____/____/____
Date

Copies of PHI should be paid for and picked up in person. With prior arrangements we may also mail or Fax. Please

CHECK if you will pick up your information in person, or should we send it to you:

Pick up Certified mail* (I will pay the costs) 1st Class US Mail* Fax*

**make sure correct address or fax number is listed above.*

FOR OFFICE USE ONLY

Client ID Verified by: _____	Form of Id: _____	Client ID/Chart # _____
Date request received: _____		Date Processed _____
Employee releasing data: _____		_____
	(name)	(title)

INSTRUCTIONS FOR THE RELEASE OF RECORDS

I. APPLICANT SECTION

- A. Client Name. Clearly write the name of the client who is the subject of the records to be released.
- B. DOB. DOB is needed to locate PHI.
- C. Address. Client's current address/phone number. If more space is needed use top of the page.
- D. Release from. Name of the provider who currently holds the Client's records.
- E. Release to. Name of the provider or individual who is authorized to receive the records.
- F. Purpose. Check appropriate box. Specify reason if check "Other".
- G. PHI to be Released. List the information, or types of information to be released.
- H. Timeframe. Note the time frame this authorization covers. (Example: all records created from July 1, 1998 through May 12, 2004, or from the onset of my pregnancy through delivery).
- I. Read and Initial Each Statement. Applicant must initial each statement. Initialing each statement only means that the applicant was informed of each factor. If the applicant refuses to initial each item, ask if there are any questions about the form.
- J. Statements to be initialed. The authorization cannot be acted upon until it is complete.
1. I may revoke this authorization. The applicant may change his/her mind and withdraw approval. Disclosures made before revocation will remain unaffected.
 2. Health care and payment will not be affected. Failure or refusal to sign this form will have no impact on how the client is treated, or on how that client's care is paid for. However, if the applicant refuses to sign the authorization, no records can be released.
 3. This Authorization will expire. The client must note when this authorization will expire. This can be a specific date such as 9/3/05, or an event, such as the "birth of my baby".
 4. There may be a charge. SLVHD is required to charge for copies made of records. Payment is usually required prior to any release of records. As a reciprocal courtesy, SLVHD does not charge for copies made for, and sent to other Medical Providers.
 5. I will receive a copy of this form. The applicant is to be given a copy.
- K. Signature of the Client (or Personal Representative). Applicant must sign and date the request.
- L. Date. The date the authorization was signed.
- M. Relationship to Client. When a Personal Representative signs the authorization, the relationship should be noted. If the client signs the authorization, applicant should note "self".
- N. Receipt of the PHI. Applicants for PHI must indicate how they prefer to receive the data. When fees will be incurred, encourage the applicant to pick up their data and pay for it at that time. In the event the applicant cannot appear, arrangements for payment should be made in advance. The applicant must also pay for all requests sent via certified mail. Do not bill a client who will pick up their records in person, payment must be made at that time.

II. OFFICE USE ONLY SECTION

- A. Client Id Verified by. Initials of employee who verified the applicants identity
- B. Form of Id. Type of verification offered to prove identity (Driver's License, State Id)
- C. Client Id/Chart #. Unique identification number assigned to the client.
- D. Date Request Received. NOTE: The request must be completed within 30 days of this date, unless other arrangements have been made.
- E. Date Processed. Date this request was completed.
- F. Employee Releasing Data. Legibly written name of the employee releasing the data.
- G. DISTRIBUTION OF COPIES: White: Office

SLVHD PRIVACY OFFICER
2001 South State St. S-2500
SLC, Utah 84190
Phone: 385-468-4114

