Emma Eccles Jones College of Education & Human Services
Sorenson Legacy Foundation Center for Clinical Excellence
UtahStateUniversity®

Authorization to Release Protected Health Information

Authorization to Release Protected Health Information Of:		
Patient Name:	Date of Birth:	Phone Number:
Address:		
Authorization to Release Protected Health Information From:		
Facility Name/ Provider:	Phone Number:	Address:
Authorization to Release Protected Health Information To:		
Facility (include contact person):	Relationship to Patient:	Phone Number:
Address:		

Purpose of Disclosure: ☐ At the request of the Individual ☐ Coordination of Care ☐ Other________________________

Dates of Treatment/Service Requested (mm/dd/yy --mm/dd/yy):

Delivery of Information:
☐ In Person ☐ Mail ☐ Oral/two-way communication ☐ Secure Email____
☐ Fax Number__________________________ ☐ Other electronic format (check with provider for available electronic options): ___________________

Release the Following Information (check all that apply):

Patient Health Information:
☐ History and Physical ☐Laboratory Reports ☐ Treatment Plan ☐ Progress Notes ☐ Consultation
☐ Discharge Summary ☐Outpatient Clinic Records ☐ Medication List ☐ Behavioral Health discharge summary
☐ Behavioral Health Evaluation/Assessment Report ☐ Behavioral Health Treatment/Therapy Notes
☐ Other____

Financial:
☐ Health Insurance Claim Form ☐Itemized Billing Statement ☐Other____

Authorization Will Remain in Effect for (unless revoked or terminated by the patient or patient's representative):
☐ 1 year from date signed ☐ one-time disclosure ☐ other(date/event/condition): ____________________________________

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written request to SCCE Compliance Office, 6405 Old Main Hill Logan, Utah 84322-6405. You should contact the clinic for the Revocation Request form. If you do revoke the authorization, it will have no effect on any actions taken prior to receiving the revocation.

Potential for Re-Disclosure: You need to be aware that information that is disclosed under this authorization could potentially be disclosed again by the person or organization receiving this information. The privacy of this information may not be protected under the Federal Privacy Regulations under these circumstances.
You may refuse to sign this authorization, signing is strictly voluntary and your treatment will not be affected by your refusal to sign.

Drug and/or Alcohol Abuse and/or Mental Health Treatment, and/or HIV/AIDS Records Release: I understand that the information disclosed may include reference to drug and/or alcohol abuse, mental health care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information.

Signature: ____ Date: ______________________________

Relationship to Patient: _______________________ Printed Name of Patient Representative (if different): ___________________________

***Important: Every section of this form must be COMPLETED to be considered valid.**
****Reasonable fees to cover copying, postage, etc. may be charged in some circumstances**

For office use only:

Received By:	Date Received:	Verification type:
		☐ DL/other state photo ID ☐ Signature verification ☐ Other (Specify):_______________________________

Effective Date: July 8, 2024