EMMA ECCLES JONES
COLLEGE of EDUCATION and HUMAN SERVICES
UtahStateUniversity

Emma Eccles Jones College of Education and Human Services

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Attn: Janel Preston. Fax 1.844.308.5865 Phone: 435.797.7165

Patient Name:____Date of Birth: __________________

Please check type of information to be used or disclosed:

☐ Medical Record ___Evaluation ___Chart Notes __All	☐ Itemized Bill	☐ Other (specify):

Please note any conditions or limitations to this authorization: ____

I hereby authorize the Developmental Behavioral Health Clinic at The Sorenson Center to (check all that apply):

☐ Exchange information with	☐ Release information to	☐ Obtain information from

Format Requested

☐ Email	☐ Fax	☐ Mail	☐ Electronic Media	☐ Other (specify)

Purpose of Request:

☐ Treatment or consultation	☐ At the request of individual ☐Other___________________	☐ Billing or claims payment ☐ CEHS Healthcare Operations

Expiration Date of Authorization: This authorization is effective through_______/______/______(not to exceed one year) unless revoked or terminated by the patient or patient's representative. Authorization will expire in 365 days.

Please disclose records to the following:

____

Name of Person/Organization

____

Address City State Zip Code

____

Phone Number Fax Number

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 Psychiatric, and/or HIV/AIDS Records Release: If my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** Yes______No_____Initials________

Signature:____Date: ____________________

Relationship to Patient_____________________Printed Name of Patient Representative (if different): ____________________

For office use only:

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

**** Original to patient chart, copy to patient*

Effective Date: September 27, 2016
Updated: July 22, 2021