AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.**

Name of Patient:_____ Date of Birth:_____ Medical Record #:_____

Social Security #:_____Patient's Telephone Number:_____

Patient's Address:_____

Patient's Therapist:_____Physician:_____Dietitian:_____

I AUTHORIZE: **Center for Change and/or its Clinical and/or Administrative Staff**
1790 North State Street, Orem, UT 84057 Telephone (801)224-8255Fax (801)224-8301

( )To disclose and ***RELEASE*** the protected health information described below ***TO***:
( ) ***REQUEST*** the protected health information described below ***FROM***:

Name/Facility:_____

Address:_____

Telephone:_____**Fax:**_____

EFFECTIVE PERIOD: This authorization for release of information covers the period of healthcare from:
( ) _____ to _____ ***OR***
( ) All past, present, and future periods

EXTENT OF AUTHORIZATION:
A. ( ) I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV, and treatment of alcohol or drug abuse).
OR
B. ( ) I authorize the release of my complete health record **with the exception of the following information**:
( ) Mental health or developmental disability treatment records (excludes "psychotherapy notes")
( ) Substance abuse treatment records
( ) Communicable diseases (including HIV and AIDS)
( ) Other_____
C. ( ) I only authorize the release of my financial information.
D. ( ) I authorize the release of my medical status only in the event of an emergency.

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:
( ) At the request of the patient or personal representative; **OR**
( ) Other:_____

EXPIRATION: This authorization will automatically expire (1) one year from the date of execution unless a different end date is specified:_____

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Center for Change Medical Records, 1790 North State Street, Orem, UT 84057.** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

RE-DISCLOSURE: I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____
Signature of Patient or Personal Representative Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

_____
Print name of personal representative Relationship to patient

INFORMATION REGARDING
CONSENT TO RELEASE MEDICAL INFORMATION
Please Read Carefully

The confidentiality of medical, psychiatric, and substance abuse information is protected by State and Federal Statutes, Rules, and Regulations. These statutes, rules, and regulations require that the patient or the patient's authorized representative give informed consent prior to the release of any records of information, except as specifically provided for within the statutes, rules, and regulations.

The patient or their authorized representative must state who may release the information, who may receive the information, the purpose for which the information may be used, what specific information may be released, and when the authorization shall expire. Authorization under these statues, rules and regulations, waives any and all rights that the patient may now have or may have in the future to bring any kind of legal action against the person or agency, their employees, agents, and servants who were authorized to release records and/or information for any damages caused by the release of said records or other confidential information directly or indirectly related thereto.

Current regulations require that all authorizations for release of information be in writing and consented to by the patient. It is recommended that all patients sixteen (16) years of age and older, consenting to the release of confidential information must consent if the information is alcohol or drug related. Patients who are under eighteen (18) also need consent of their parent or authorized representative. Authorized representatives, other than natural parents, signing with or for the patient must submit certified copies of the legal documents supporting the assignment of this authority.

Authorized representatives, including adoptive parents, conservators, agents of the court if the patient is a ward of the court, and Executor/Administrator of a deceased patient's estate, next of kin, and/or spouses are not automatically an authorized representative and must submit certified copies of legal documents as described above.

Physicians may determine that release of information may result in substantial risk of significant adverse or detrimental consequences to the patient and must approve some types of releases of information. Patient who are concerned about the release of their confidential information are advised to seek the advice of their physician and/or attorney prior to signing this consent form.

Persons or agencies receiving information authorized by this consent are required by certain State and Federal Statutes, Rules, and Regulations to use the records and/or information only for the authorized purpose. Additionally, these statutes, rules, and regulations contain specific requirements related to the re-release of the information received, generally prohibiting such re-disclosure without patient authorization.

Release of information without patient authorization may be made to the extent necessary for the recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he may be entitled except for records of alcohol and/or drug abuse patients. Patients entitled to protection under 42 C.F.R. Section 2.37 must sign an authorization to release information to third party payers and other agencies to which they may be entitled to aid. Disclosure of Substance Abuse Patient records without patient's consent is a Federal Criminal Offense punishable by a fine of not more than $500.00 in the case of a first offense, and not more than $5000.00 in the case of each subsequent offense.