SALT LAKE COUNTY HEALTH DEPARTMENT

Authorization for SLCoHD to Release Records

(HIPAA-covered Programs Only)

Submit completed form to HealthPrivacy@slco.org

I hereby authorize the disclosure of my protected health information **(PHI)** (or that of an un-emancipated minor for whom I have legal authority) as described below. I understand that this authorization is voluntary and that any information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. **I understand that requests require photo identification** and may take up to 30 days to complete**.**

THIS AUTHORIZATION IS FOR RELEASE OF PHI FOR THE FOLLOWING CLIENT:

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____State: _____ ZIP: _____

Release information **from** (person/organization providing the PHI):	Release information **to** (name or identifying information):
_____Salt Lake County Health Department_____	_____

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

PHI to be released (describe information): _____

_____

This authorization is limited to PHI created 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, SLCoHD will follow my instructions to the extent 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.
_____ 2. My health care and payment for my health care will not be denied if I do not sign this form.
_____ 3. This authorization expires on: _____ or upon the occurrence of _____.
_____ 4. There may be a charge for complying with this request.
_____ 5. I will receive a copy of this form after I sign it.

_____	_____	_____
Signature of Client (or Personal Representative)	Relationship to Client	Date

Copies of PHI should be paid for and picked up in person. With prior arrangement, we may also mail or fax (medical offices only). Please check below how you should receive the requested records (if by mail, confirm address above):

☒ Pick up in person; ☐ Certified mail (I will pay the cost); ☐ 1st class mail; ☐ Fax (number: _____)

FOR OFFICE USE ONLY

Form of ID: _____ USIIS Record Only: Y

ID verified by: _____ Client ID/Chart #: _____

Date request received: _____ Date processed: _____

Employee releasing data: _____

Print