Utah Healing Center

AUTHORIZATION

To Use and Disclose Protected Health Information

**Required fields must be completed in order to process request.*

*Client Name:						*DOB:	
*Address:						Home#:	
*City:		*State:		*Zip:		Cell#:	
Email:						Work#:	

Utah Healing Center follows Federal and State confidentiality regulations prohibiting release of your protected health information without your permission. We can provide you with a copy of our Notice of Privacy Practices. Substance Abuse treatment records have additional privacy protections (42 CFR Part 2). I understand that use and disclosure means sharing my medical records includes verbal and written communication. I give permission for Utah Healing Center and the person and/or organization listed below to share my medical (including prescription drug history), mental health, and/or substance abuse treatment records:

NAME OR OTHER SPECIFIC IDENTIFICATION OF PERSON(S) AUTHORIZED TO RECEIVE/MAKE THE REQUESTED USE OR DISCLOSURE:

*Agency/Name:					*Attn:		
*Address:						*Phone:	
*City:		*State:		*Zip:		Fax#:	

EXPIRATION: Date or Event _____ - OR – one year from date signed unless revoked

***DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:**

( ) Admission ( ) Discharge ( ) Evaluations ( ) Progress Notes ( ) Medication Notes ( ) Drug Test
( ) Diagnosis ( ) Care Plan ( ) Group Notes ( ) Prescription Hx ( ) Billing records
( ) Treatment and/or Compliance ( ) Other: _____

NOTICE TO CLIENT: I understand I may revoke this authorization at any time. To revoke this authorization, I will need to send a written notice to Utah Healing Center. Verbal revocation will only be honored for drug and/or alcohol treatment records. Revocation will not include any information already shared in reliance upon this authorization. Signing this form is voluntary and not required in order to receive services at Utah Healing Center. I understand once the information is shared, it is no longer protected.

ACCESS TO MY RECORD: I understand I can request a copy of my record. This request will be reviewed and approved by my therapist. This can take up to 30 days to complete and charges may apply. I understand I can also review my records with my therapist by making an appointment.

*Client Signature»	*Date»
*Representative Signature»	*Date»
*Representative Name (print)»	*Relationship»
*Witness Signature»	*Date»

UTAH HEALING CENTER CONTACT INFORMATION:

Name:	Utah Healing Center						Attn:		
Address:	5284 S. Commerce	Dr.	Suite C-134					Phone#:	801-266-4643
City:	Murray		State:	Utah	Zip:		84107	Fax#:	801-266-4775