

## Authorization to Release Records to ARUP Family Health Clinic

### DISCLOSURE OR RECEIPT OF PROTECTED HEALTH INFORMATION

**Patient Name**

**Date of Birth**                      **Phone #**                      **Medical Record #**

**Patient Address**

1. I authorize the following healthcare provider or facility to **RECEIVE** my patient information:

**Provider**

**Name:** ARUP Family Health Clinic **Address:** 500 Chipeta Way, Salt Lake City, UT 84108 **Fax:** (801) 584-5206

2. I authorize the following person or organization to **DISCLOSE** my patient information:

**Name**                                      **Phone #**                                      **Fax #**

**Address**

Name and contact information of the clinic that has your records

3. Please disclose the following information pertaining to a diagnosis or event (check to indicate your selection):

**Date(s) of Treatment**                      (The treatment episode must have already occurred.)

Date(s) of treatment you want included on records

- History and physical       Vaccinations       Other: \_\_\_\_\_
- Consultation reports       Lab reports      \_\_\_\_\_

I give my permission for the following information to be released (please check and initial):

- \_\_\_\_\_  HIV/AIDS-related information
- \_\_\_\_\_  Alcohol/drug treatment information
- \_\_\_\_\_  Sexually transmitted diseases
- \_\_\_\_\_  Mental health (other than psychotherapy notes)
- \_\_\_\_\_  Psychotherapy notes
- (By checking this box, I am waiving any psychotherapist-patient privilege.)

What information you would like released and sent

4. Please describe the purpose of the disclosure. The purpose must be specific to the request and not for future unspecified treatment.

\_\_\_\_\_

\_\_\_\_\_

The reason you need this information

Date and sign the back of this page.

5. I understand that if the authorized recipient of this information is not a healthcare provider or health plan covered by federal privacy regulations, the information he/she/it receives will no longer be protected by these regulations, and the recipient may redisclose the information. However, the recipient may be prohibited from disclosing substance abuse records from a federally funded substance abuse treatment program.
6. I understand that ARUP Laboratories will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: ARUP Laboratories Privacy Officer, 500 Chipeta Way, Salt Lake City, Utah 84108.

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 90 days from the date I sign below.

Signature of Patient or Representative	Date
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Patient Name	Name of Personal Representative (if applicable)
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If signing as personal representative, describe authority to act for patient and submit documentation, such as power of attorney, showing such authority.

Witness (required if patient signs in the presence of ARUP Laboratories' staff)

(Notarization is not required if patient appears personally at ARUP Laboratories' facility and presents valid identification.)

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Residence

\_\_\_\_\_  
Date Commission Expires

(This signature page authorizes the release of records to the ARUP Family Health Clinic.)

