Authorization for SLCoHD to Release Records

(HIPAA-covered Programs Only)

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):

______Salt Lake County Health Department______

Release information **to** (name or identifying information):

____

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 N N/A

ID verified by: ________________________________ Client ID/Chart #: ___________________________

Date request received: __________________________ Date processed: ____________________________

Employee releasing data: ____

Instructions for the Release of Records

A. **Client Name:** Clearly write the name of the client who is the subject of the records to be released.
B. **DOB:** DOB is needed to locate PHI.
C. **Address:** Client's current address/phone number.
D. **Release from:** Name of the provider who currently holds the client's records.
E. **Release to:** Name of the provider or individual who is authorized to receive the records.
F. **Purpose:** Check appropriate box; specify reason if checking "Other."
G. **PHI to be Released:** List the information, or types of information, to be released.
H. **Timeframe:** Note the time frame this authorization covers. (Example: "All records created from July 1, 1998 through May 12, 2004," or "from the onset of my pregnancy through delivery.")
I. **Read and Initial Each Statement**: Applicant must initial each statement. Initialing each statement only means that the applicant was informed of each factor. If the applicant refuses to initial each item, ask if there are any questions about the form.
J. **Statements to be initialed:** The authorization cannot be acted upon until it is complete.
    1. **I may revoke this authorization.** The applicant may change his/her mind and withdraw approval. Disclosures made before revocation will remain unaffected.
    2. **Health care and payment will not be affected.** Failure or refusal to sign this form will have no impact on how the client is treated, or on how that client's care is paid for. However, if the applicant refuses to sign the authorization, no records can be released.
    3. **This authorization will expire.** The client must note when this authorization will expire. This can be a specific date such as 9/3/05, or an event, such as the "birth of my baby."
    4. **There may be a charge.** SLCoHD is required to charge for copies made of records. Payment is usually required prior to any release of records. As a reciprocal courtesy, SLCoHD does not charge for copies made for and sent to other medical providers.
    5. **I will receive a copy of this form.** The applicant is to be given a copy.
K. **Signature of the Client (or Personal Representative):** Applicant must sign and date the request.
L. **Date:** The date the authorization was signed.
M. **Relationship to Client:** When a personal representative signs the authorization, the relationship should be noted. If the client signs the authorization, applicant should note "self."
N. **Receipt of the PHI:** Applicants for PHI must indicate how they prefer to receive the data. When fees will be incurred, encourage the applicant to pick up their data and pay for it at that time. In the event the applicant cannot appear, arrangements for payment should be made in advance. The applicant must also pay for all requests sent via certified mail. Do not bill a client who will pick up their records in person; payment must be made at that time.

OFFICE USE ONLY SECTION

A. **Client ID verified by:** Initials of employee who verified the applicant's identity.
B. **Form of ID:** Type of verification offered to prove identity (driver license, state ID).
C. **Client ID/Chart #:** Unique identification number assigned to the client.
D. **Date request received:** The request must be completed within 30 days of this date unless other arrangements have been made.
E. **Date processed.** Date this request was completed.
F. **Employee releasing data:** Legibly written name and title of the employee releasing the data.
G. **DISTRIBUTION OF COPIES:** White: Office.

SLCoHD Privacy Officer
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