SALT LAKE COUNTY HEALTH DEPARTMENT

Autorización al SLCoHD para liberar registros

(Sólo para programas cubiertos por HIPAA)

Envíe el formulario completo a HealthPrivacy@slco.org

Por la presente autorizo la divulgación de mi información médica protegida **(PHI)** (o la de un niño menor de edad no emancipado sobre el que tengo autoridad legal) según se describe debajo . Entiendo que esta autorización es voluntaria y que cualquier información liberada puede estar sujeta a re-divulgación por el recipiente y ya no estar protegida por ley estatal o federal. **Entiendo que las solicitudes requieren una identificación con foto** y pueden tardar hasta 30 días en completarse.

ESTA AUTORIZACIÓN ES PARA LIBERAR INFORMACIÓN DE SALUD DEL CLIENTE:

Nombre: _____ Fecha de Nacimiento: _____

Dirección: _____ Teléfono: _____

Ciudad: _____ Estado: _____ ZIP: _____

Información liberada de:
(persona/organización que provee la información):

_____Salt Lake County Health Department_____

Liberar información a:
(Nombre o información identificatoria):

_____

¿Por qué desea liberar?: ☐ Atención médica; ☐ Pedido por cliente; ☐ Otro (especifique): _____

PHI a ser liberada (describa la información)**:** _____

_____

Esta autorización está limitada a la PHI creada durante el periodo de tiempo entre _____ a _____.

También entiendo que puedo limitar la información a ser liberada, especificando cuáles son los registros necesarios. Si más adelante autorizado a liberar.

El cliente o su representante personal deberá leer e inicialar las siguientes declaraciones:

Entiendo que:

_____ 1. Yo puedo revocar esta autorización en cualquier momento con notificatión escrita al Oficial, Coordinador de privacidad o el designado enviándola a la dirección indicada en el dorso. Si yo revocara, entiendo que esta decisión no tendrá efecto sobre acciones tomadas previamente al recibo de la revocación.
_____ 2. Mi atención médica y el pago de la misma no podrán negarse si no firmo este formulario.
_____ 3. Esta autorizacióvence el: _____ o cuando ocurra el acontecimiento de _____.
_____ 4. Puede haber un cargo por cumplir con este pedido.
_____ 5. Recibré una copia de esta formulario después que lo haya firmado.

_____ _____ _____
Firma del cliente (o su Representante Personal) Parentesco con el cliente Fecha

Las copias de la PHI deben ser pagados y recoger en persona. Con acuerdo previo, también podemos enviar por correo o fax (sólo consultorios médicos). Por favor, indique a continuación cómo se debe recibir los registros solicitados (si es por correo electrónico, confirme la dirección arriba):

☐ En persona; ☐ Correo certificado* (Yo pago los costos); ☐ Correo 1ra.clase; ☐ Fax (number: _____)

FOR OFFICE USE ONLY

Print

Form of ID: _____ Date received: _____ Date processed: _____

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

USIIS Record Only: Y N N/A Employee releasing data: _____

Nurse signature: _____ ☐ X0600 ☐ 101.10

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.

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