Davis Behavioral Health
934 South Main Street, Layton, UT 84041 / PH:(801) 773-7060

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

FOR PURPOSES OF TREATMENT, PAYMENT, AND OPERATIONS

Name: _____ Date of Birth: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____
Former Name: _____ Phone Number: _____

SECTION A: USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Davis Behavioral Health **("DBH")** to use and disclose my health information to the **Recipient(s)** named below. I also expressly authorize DBH to use and disclose any confidential information disclosed by me to DBH treatment staff.

Recipient(s):

Individuals and organizations which provide treatment, payment and operational support for my care
Print Name or Organization

SECTION B: SPECIFIC INFORMATION TO BE RELEASED

- ☐ Psychiatric Evaluation/Assessment
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Medication History
- ☐ Discharge Summary
- ☐ Substance Use Disorder Records
- ☐ Other: _____

Please choose:

- ☐ Verbal communication only
- ☐ Verbal communication and send records now
- ☐ Verbal communication now, but send records later (when I give notice)
- ☐ Letter or form signed by my provider

Note: DBH will only send previous two years of records to Recipient(s), unless I write another date range here: _____

SECTION C: PURPOSE OF THE USE AND DISCLOSURE

- ☒ Treatment, Payment and Healthcare Operations ("TPO")

Note: The patient's signed authorization is only required for TPO disclosures of health information that relate to substance use disorder services. All other disclosures of health information for purposes of TPO may be made even without the patient's specific authorization. See 45 CFR 164.506.

SECTION D: EXPIRATION

This Authorization will stay in effect until my discharge from treatment, unless I write another date or event here: _____

I may revoke this authorization at any time by delivering written notice to the front desk of any DBH facility or by mailing my notice to the Medical Records Office – HIPAA Specialist at 934 S Main Street, Layton, UT 84041. However, my revocation will not have effect on any action taken by DBH before they received my written notice.

SECTION E: OTHER IMPORTANT INFORMATION

- Health information includes personally identifiable and protected health information as defined by applicable privacy regulations, including "Confidentiality of Substance Use Disorder Patient Records" and the "Health Insurance Portability and Accountability Act."
- I may choose to not sign this Authorization and it will not prevent me from getting treatment at DBH.
- DBH cannot guarantee that the Recipient will not re-disclose my health information. The Recipient may or may not be subject to privacy regulations. Any authorized disclosure of health information relating to substance use disorder services will include the following notice:

Davis Behavioral Health Substance Use Disorder Redisclosure Notice
PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

- This notice accompanies a disclosure of information concerning a patient in a substance use disorder treatment program, made to you by authorization of such patient or as otherwise permitted by federal regulations.
- Federal regulations prohibit you from making any further disclosure of this information unless authorized by the patient or otherwise permitted by 42 CFR Part 2.
- A general authorization for the release of medical or other information is **not** sufficient for this purpose.
- Federal regulations restrict any use of the information to criminally investigate or prosecute any patient of substance use disorder services.

I have read, understood, and had opportunity to ask questions about the terms of this Authorization.

Patient signature:_____ Date of signature: _____

Print patient's full name: _____

Staff Member/Witness Signature: _____ Date of signature: _____

Relationship to patient:_____

If patient is unable to sign this Authorization (e.g. incapacitated), the signature of a parent, guardian, or other legal representative is required.

Signature of legal representative: _____ Date of signature:_____

Print legal representative's name: _____ Relationship to patient:_____